



Application Number _____

Date Received _____

Date Approved _____

A Division of Lutheran Retirement Ministries of Alamance County, North Carolina

APPLICATION FOR RESIDENCY

A non-refundable \$700 fee is required with application submittal. Updated health and financial information, along with supporting documentation, will be requested before a contract is executed.

FOR APPLICANT:

1. Name _____
Last First Middle

2. Street Address _____
City/State Zip _____

3. Telephone Number _____

4. Date of Birth _____

5. Email Address _____

6. Emergency Contact:

Name _____

Address _____

City/State _____

Relationship _____

Phone Number _____

7. Marital Status: Married Single Widowed
 Divorced Remarried Domestic Partners

15. Desired date for residency (Please be as specific as possible.) _____

16. Type of accommodations requested:

Aldersgate and Brandenburg Apartments: Heather Laurel

Wittenberg Apartments: Edelweiss Iris Valerian

Stockton Apartments: Magnolia Oak Poplar Redbud Sycamore Tupelo Willow

Villas: Acacia Aspen Chestnut Birch Dogwood

Garden Homes: Juniper Evergreen Forsythia Gardenia Holly

FOR CO-APPLICANT:

8. Name _____
Last First Middle

9. Street Address _____
City/State Zip _____

10. Telephone Number _____

11. Date of Birth _____

12. Email Address _____

13. Emergency Contact:

Name _____

Address _____

City/State _____

Relationship _____

Phone Number _____

14. Marital Status: Married Single Widowed
 Divorced Remarried Domestic Partners

FOR APPLICANT:

17. Where have you lived most of your life? _____

18. Vocations or professions in which you have engaged _____

19. Skills, Interests, Hobbies _____

FOR CO-APPLICANT:

20. Where have you lived most of your life? _____

21. Vocations or professions in which you have engaged _____

22. Skills, Interests, Hobbies _____

FOR BOTH APPLICANTS:

23. How did you first hear about Twin Lakes? _____

24. What appealed to you most about Twin Lakes? _____

HEALTH INSURANCE

APPLICANT

Traditional Medicare Part A [] Yes [] No
Replacement or Advantage Medicare Plan [] Yes [] No
Supplemental/Extended Ins. [] Yes [] No
Name of Company _____

Long-term Care? _____ Annual Premium _____
Benefit Period _____ Daily Benefit _____
Elimination Period _____ Inflation Adj. _____
Company Name _____

CO-APPLICANT

Traditional Medicare Part A [] Yes [] No
Replacement or Advantage Medicare Plan [] Yes [] No
Supplemental/Extended Ins. [] Yes [] No
Name of Company _____

Long-term Care? _____ Annual Premium _____
Benefit Period _____ Daily Benefit _____
Elimination Period _____ Inflation Adj. _____
Company Name _____

APPLICANT FINANCIAL DATA

The following information is required to assure us that your financial resources will be adequate to fulfill your responsibilities at Twin Lakes Community. Please do not omit any assets, obligations or income sources on the following financial statement. If there are assets that you do not ever intend to liquidate, please share details on the nature of the assets and the reason you intend not to liquidate. The information supplied is strictly confidential. Your privacy is very important to us and is therefore reviewed only by Sales and Marketing, our CFO, and CEO. It is securely stored under lock and key.

ASSETS*

APPLICANT

CO-APPLICANT

(check box if jointly held account)

Cash NOT held in a trust or retirement account \$ _____ [] \$ _____
(including checking accounts, savings accounts, money market accounts, and certificates of deposit)

Funds in Trust (**copy of trust must be attached**) \$ _____ [] \$ _____

Notes Receivable (**attach schedule**) \$ _____ [] \$ _____

Annuity NOT held in a trust or retirement account .. \$ _____ [] \$ _____
(attach annuity policy summary from the issuing insurance company)

- Do you have unrestricted access to the principal balance of the annuity? [] Yes [] No [] Yes [] No
- Is there a penalty associated with early withdrawal? [] Yes [] No [] Yes [] No
- If yes, what percentage? _____% _____%

Traditional IRA/401(k) \$ _____ \$ _____

Roth IRA \$ _____ \$ _____

Marketable Securities

Stocks/Equity Funds \$ _____ [] \$ _____

Bonds/Bond Funds \$ _____ [] \$ _____

Primary Residence \$ _____ [] \$ _____

- Do you intend to sell upon entry? [] Yes [] No

Other Real Estate \$ _____ [] \$ _____

Please provide information about the use (vacation, rental, commercial), revenue and expenses, and your ownership percentage.

- Do you intend to sell upon entry? [] Yes [] No

Other Assets (attach schedule) \$ _____ [] \$ _____

DO NOT include autos, antiques, household goods, etc.

TOTAL ASSETS \$ _____ [] \$ _____

Will all assets be inherited by surviving applicant? [] Yes [] No *If no, please attach explanation.*

**Documentation of all assets and income will be required at the time a specific home is chosen for residency prior to the issuance of a contract.*

LIABILITIES

Home Mortgage \$ _____ [] \$ _____

Auto and Credit Card Debt \$ _____ [] \$ _____

Other Liabilities or Debt Guarantees (attach schedule) \$ _____ [] \$ _____

TOTAL LIABILITIES \$ _____ [] \$ _____

NET ASSET BALANCE \$ _____ [] \$ _____

LIFE INSURANCE

Face Value of Applicant’s Policy \$ _____ Face Value of Co-Applicant’s Policy \$ _____

Applicant’s Beneficiary _____ Co-Applicant’s Beneficiary _____

If this is a term life policy please provide expiration date of policy: Applicant _____ Co-Applicant _____

If this is a whole life policy, please provide cash value amount: Applicant _____ Co-Applicant _____

MONTHLY INCOME

APPLICANT

CO-APPLICANT

Social Security.....	\$ _____	\$ _____
Private Pension	\$ _____	\$ _____
• surviving spouse benefit percentage?	_____ %	_____ %
Traditional IRA/401(k)	\$ _____	\$ _____
Roth IRA	\$ _____	\$ _____
Annuities not held in an IRA.....	\$ _____	\$ _____
Installment Notes	\$ _____	\$ _____
Rental Income.....	\$ _____	\$ _____
Dividend Income	\$ _____	\$ _____
Interest Income.....	\$ _____	\$ _____
Other (attach schedule)	\$ _____	\$ _____

TOTAL MONTHLY INCOME	\$ _____	\$ _____
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ANTICIPATED MONTHLY EXPENSES (Those NOT included in the Twin Lakes monthly fee)

Estimated monthly living expenses	\$ _____	\$ _____
(such as food, car, entertainment, personal items)		
Estimated monthly medical expenses	\$ _____	\$ _____
(including prescription medications, copay/deductible payments, etc.)		
Monthly insurance payments; <i>do not include LTC premiums</i>	\$ _____	\$ _____
(including health, life, personal property, auto)		
Family Support/Alimony*.....	\$ _____	\$ _____

TOTAL MONTHLY EXPENSES	\$ _____	\$ _____
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*Please list any support you provide, whether or not you are legally obligated to provide the support.

I certify that the foregoing information is a true and complete statement of facts regarding my financial status as known to me.

Applicant Signature _____

Date _____

Co-Applicant Signature _____

Date _____

SELF-STATED PERSONAL HEALTH HISTORY

History and Physical (H&P) documentation must be obtained from your physician and included with your application. The application is considered incomplete without the H&P information.

APPLICANT INFORMATION

1. Applicant Name _____
2. Estimate, in your own words, the condition of your health. _____

3. Please list your current: Age _____ Weight _____ Height _____
4. Do you or have you ever had any of the following? (check all that apply)

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney Failure/Dialysis	<input type="checkbox"/> Glaucoma or Macular Degeneration
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Spinal Stenosis
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Parkinson's or Other Neurological Disorders	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Circulatory Problems or Swelling in Feet or Legs
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Memory Difficulties	<input type="checkbox"/> Other Chronic Conditions (list below)
<input type="checkbox"/> Heart Disease or History of Heart Attack	<input type="checkbox"/> Difficulty Ambulating	
<input type="checkbox"/> Stroke		

5. Please describe any mobility limitations.

6. Do you use any of the following equipment?

<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Power Chair/Scooter	<input type="checkbox"/> In Home Dialysis Equipment
<input type="checkbox"/> Walker	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Feeding Tube
<input type="checkbox"/> Cane	<input type="checkbox"/> Hoyer Lift	
7. Describe in detail any mental illnesses, memory loss or substance abuse/alcoholism you have experienced. Please specify diagnosis, date of onset, and current status.

8. Describe any past surgical operations, serious illnesses or hospitalizations. Please give dates and details.

9. Do you smoke? Yes No

Twin Lakes Community is a tobacco-free community. Use of tobacco products is strictly prohibited.

10. Do you require any assistance with:
 Dressing Bathing Ambulating/Walking Meal Preparation Taking Medications
11. Do you drive? Yes No
12. Do you live independently? Yes No If no, please describe current arrangements. _____

13. Please list your current primary care physician.
 Name _____
 Address _____
 Phone _____
14. Do you see any specialty physicians? Please check all that apply.
 Neurologist Psychotherapist/Psychiatrist Cardiologist Other
 What conditions are you seeing these specialists for? _____

15. What are your current medications? _____

16. What medications, not listed in number 15, have you taken in the last year? _____

17. Please list any other pertinent health history or diagnosis not mentioned above. _____

18. Do you have any medical/personal care services you would be anticipating Twin Lakes Community to provide upon residency? If so, please describe. _____

The medical and personal information submitted by the applicant within this self-stated personal health history is a material part for determination of a contract agreement. Any misrepresentation or omissions are considered a breach of contract, permitting the contract to be declared null and void.

Date _____ Applicant Signature _____

SELF-STATEMENT PERSONAL HEALTH HISTORY

History and Physical (H&P) documentation must be obtained from your physician and included with your application. The application is considered incomplete without the H&P information.

CO-APPLICANT INFORMATION

1. Applicant Name _____
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3. Please list your current: Age _____ Weight _____ Height _____
4. Do you or have you ever had any of the following? (check all that apply)

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