



Application for Residency

1st Applicant: _____
 (please print full name)

2nd Applicant: _____
 (please print full name)

Today's Date: _____ Expected Date of Entry: _____

Accommodation Preference:		
	Bahnson Hall / Vogler	Driscoll Building
<input type="checkbox"/> Apartment (please be as specific as possible, you may choose more than one, number in preferential order)	<input type="checkbox"/> Ardmore (studio) <input type="checkbox"/> Forsyth (1 BR) <input type="checkbox"/> Winston (2 BR) <input type="checkbox"/> West End (1 BR) <input type="checkbox"/> Buena Vista (2 BR)	<input type="checkbox"/> Reynolda (1 BR) <input type="checkbox"/> Sherwood (1 BR w/ Den) <input type="checkbox"/> Piedmont (2 BR) <input type="checkbox"/> Brookstown (2 BR corner) <input type="checkbox"/> Twin City (2 BR w/ Den)
<input type="checkbox"/> Cottage (please be as specific as possible, you may choose more than one number in preferential order)	<input type="checkbox"/> Bethabara Place <input type="checkbox"/> Salem Village <input type="checkbox"/> Wachovia Village	<input type="checkbox"/> 2 BR <input type="checkbox"/> 2 BR w/ den <input type="checkbox"/> 2 BR w/ sunroom <input type="checkbox"/> 2 BR w/ den & sunroom

Application Procedure

Salemtowne accepts applications from persons age 62 years or older, or in the case of a joint application, one of the two persons must be 62 years or older. Eligible applicants will be considered without regard to their sex, race, religion, color, national origin, political beliefs, or ancestry. For joint applicants please complete separate applications, but only complete one financial disclosure.

Please indicate your intentions:

- Application for **Waiting List** - for applicants who wish to reserve a spot in the future.
 - Complete application
 - Submit \$100* for waiting list fee
- Application for **Ready List** – for applicants who are ready to move as soon as possible.
 - Complete application
 - Provide copies of your Medicare & Supplementary Insurance Cards
 - Submit \$100* for ready list fee

*non-refundable fee

Steps to Move-in:

Once an accommodation is available and you are ready to move you will need to provide documentation of your assets and income, as follows:

- Property tax statement(s).
- 1st page of your most recent Federal Income Tax Return
- Supporting documentation of assets and income (i.e. bank statements, brokerage statements, statements detailing shares of stock owned if not managed by a broker, etc)
- Documentation of Trust that indicates whether the trust is revocable or irrevocable, if applicable.
- Copy of your Medicare Card and Supplementary Insurance card

Once you have been financially approved you will need to submit:

- Completed Physician's Health form
- Complete a nursing assessment at Salemtowne

Reservation of an accommodation:

- Remit 10% as a reservation deposit
- Sign reservation agreement

How many different ways did you hear about Salemtowne?

- | | |
|--|--|
| <input type="checkbox"/> Always known about | <input type="checkbox"/> Salemtowne's website |
| <input type="checkbox"/> Friend / Family | <input type="checkbox"/> other website _____ |
| <input type="checkbox"/> Phone Book | <input type="checkbox"/> Resident |
| <input type="checkbox"/> Radio (Station: _____) | <input type="checkbox"/> Winston-Salem Journal |
| <input type="checkbox"/> Magazine (title: _____) | <input type="checkbox"/> Senior Services |
| <input type="checkbox"/> Hospital (Name: _____) | <input type="checkbox"/> Other _____ |

Confidential Profile

First Applicant

Title: Mr. Mrs. Dr. Ms. Miss Rev.

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Email: _____

Home Phone: _____ Other Phone: _____ (type) _____

Social Security: _____ Date of Birth: _____

Medicare Number #: _____ Do you have: Part A Part B
Please provide copy

Supplemental Medicare Insurance Company: _____
Please provide copy

Policy #: _____ Group #: _____

Do you have prescription coverage? _____

If yes, describe _____

Health Information

Current Physician: _____ Phone: _____

Please list all medical conditions: (including problems addressed by psychiatrist) (current and past):

Do you currently receive assistance in your home? Yes No If yes, please list type & duration: _____

****List the medications you now take on a separate sheet of paper: (include over-the-counter and herbal preparations)**

Please list any known allergies (food and/or drug): _____

Do you have or have you had any of the following?

- | | | | |
|------------------------------|--|-------------------------------------|--|
| Alcoholism or Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack (date: _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Black out spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bladder/Bowel Incontinence | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease, Hepatitis, Cirrhosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental disease/disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dementia or Alzheimer's | <input type="checkbox"/> Yes <input type="checkbox"/> No | (Type: _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease, Asthma, Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye disease or blindness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke or TIA | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | TB | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Confidential Profile

Second Applicant

Title: Mr. Mrs. Dr. Ms. Miss Rev.

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Email: _____

Home Phone: _____ Other Phone: _____ (type) _____

Social Security: _____ Date of Birth: _____

Medicare Number #: _____ Do you have: Part A Part B
Please provide copy

Supplemental Medicare Insurance Company: _____
Please provide copy

Policy #: _____ Group #: _____

Do you have prescription coverage? _____
If yes, describe _____

Health Information

Current Physician: _____ Phone: _____

Please list all medical conditions: (including problems addressed by psychiatrist) (current and past):

Do you currently receive assistance in your home? Yes No If yes, please list type & duration: _____

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| | | TB | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Emergency Contact Information

Children / Close Family / Friends (please list in order of persons to contact)

Name: _____ Relation/POA: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Name: _____ Relation/HCPOA: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Name: _____ Relation: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Name: _____ Relation: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Name: _____ Relation: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Financial Disclosure - Confidential

Assets:	<u>Balance</u>	<u>Annual Income</u>
Investment Account _____	\$ _____	\$ _____
Investment Account _____	\$ _____	\$ _____
Investment Account _____	\$ _____	\$ _____
Certificates of Deposit _____	\$ _____	\$ _____
Cash (Checking, Savings, or Money Market) _____	\$ _____	\$ _____
Annuity _____	\$ _____	\$ _____
Real Estate (Tax Value) _____	\$ _____	\$ _____
Real Estate (Tax Value) _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
Total Assets:	\$ _____	\$ _____

Income:	<u>Monthly Income</u>	To applicant (1) if applicant (2) <u>predeceases</u>	To applicant (2) if applicant (1) <u>predeceases</u>
Social Security (1 st applicant) _____	\$ _____	\$ _____	\$ _____
Social Security (2 nd applicant) _____	\$ _____	\$ _____	\$ _____
Pension _____	\$ _____	\$ _____	\$ _____
Pension _____	\$ _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____	\$ _____
Total Income:	\$ _____		

Do you have any debts/liabilities? If yes please describe amounts owed. _____

Do you have Long Term Care Insurance? Yes No

Company: _____ Policy number: _____

Benefit per day: \$_____ In Home Care \$_____ Assisted Living \$_____ Skilled Nursing
 Maximum Coverage: _____ Elimination Period: _____

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 Maximum Coverage: _____ Elimination Period: _____

Application Signatures

The information provided in the Confidential Financial Disclosure is true and may be relied upon with confidence by Salemtowne Management in my (our) residency application process. I (we) understand that additional information may be requested from time to time. I (we) will not transfer or reduce resources necessary to carry out the financial commitment to Salemtowne.

Salemtowne respects your right to privacy and safeguards the confidential personal information you provide us in this Application. Except as set forth below, Salemtowne will not disclose any confidential personal information it gathers from you. We may release such personal information to affiliates, agents, and third parties to comply with valid legal requirements such as a law, regulation, or court order; or in special cases, such as for your own health, benefit or welfare. We require all affiliates, agents, and third parties to treat your information confidentially. In the event that we are legally compelled to disclose such personal information to a third party, we will notify you unless doing so would violate the law or court order. Under no circumstances do we sell confidential personal information to third parties for marketing purposes.

I (we) hereby declare that all statements made herein are true and complete according to my (our) best knowledge and belief. In witness whereof, I (we) have set my (our) hand to this application this _____ Day of _____, 20 ____.

1st Applicant Signature (or POA)

Co- Applicant Signature (or POA)

