EQUAL HOUSING OPPORTUNITY

Twin Lakes COMMUNITY

Application Number _____

Date Received _____

Date Approved _____

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

APPLICATION FOR RESIDENCY

A non-refundable $250 fee is required with application submittal.
Updated health and financial information may be requested before a contract is executed.

FOR APPLICANT:

1. Name _____ (Last / First / Middle)

2. Street Address _____

City/State Zip _____

3. Social Sec. Number _____

4. Telephone Number _____

5. Date of Birth _____

6. Email Address _____

7. Emergency Contact:

Name _____

Address _____

City/State _____

Relationship _____

Phone Number _____

8. Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Remarried

FOR CO-APPLICANT:

9. Name _____ (Last / First / Middle)

10. Street Address _____

City/State Zip _____

11. Social Sec. Number _____

12. Telephone Number _____

13. Date of Birth _____

14. Email Address _____

15. Emergency Contact:

Name _____

Address _____

City/State _____

Relationship _____

Phone Number _____

16. Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Remarried

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

18. Type of accommodations requested:

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 APPLICANT:

11. Financial Power of Attorney_____

12. Medical Power of Attorney_____

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

14. Vocation(s) or profession(s) in which you have engaged_____

15. Skills, Interests, Hobbies_____

_____

16. Community Service_____

_____

FOR CO-APPLICANT:

11. Financial Power of Attorney_____

12. Medical Power of Attorney_____

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

14. Vocation(s) or profession(s) in which you have engaged_____

15. Skills, Interests, Hobbies_____

_____

16. Community Service_____

_____

FOR BOTH APPLICANTS:

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

_____

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

_____

_____

RESIDENT 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. If there are assets that will never be liquidated, please discuss these with the Sales and Marketing representative. The information supplied is strictly confidential. The decision to admit or not admit an applicant is made by Twin Lakes Community at its sole discretion. The applicant agrees to such decision as binding and final in all aspects.

ASSETS*

	APPLICANT (check box if jointly held account)		CO-APPLICANT
Cash on Deposit (including checking accounts, savings accounts, money market accounts, and certificates of deposit)	$_____	☐	$_____
Notes Receivable (***attach schedule***)	$_____	☐	$_____
Marketable Securities			
Stocks/Equity Funds (current value)	$_____	☐	$_____
Bonds/Bond Funds (current value)	$_____	☐	$_____
Funds in Trust (***copy of trust must be attached***)	$_____	☐	$_____
Primary Residence (current market value)	$_____	☐	$_____
Do you intend to sell upon entry? ☐ Yes ☐ No			
Other Real Estate (current market value)	$_____	☐	$_____
Do you intend to sell upon entry? ☐ Yes ☐ No			
Annuity (include balance)	$_____	☐	$_____
Do you have unrestricted access to the principal balance of the annuity? ☐ Yes ☐ No			
Is there a penalty associated with early withdrawal? ☐ Yes ☐ No If yes, what percentage? _____			
Traditional IRAs/401K (balance)	$_____		$_____
Roth IRAs (balance)	$_____		$_____
Other Assets (attach schedule) (**DO NOT** include autos, antiques, household goods, etc)	$_____	☐	$_____
TOTAL ASSETS	$0.00	☐	$0.00

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	$0.00	☐	$0.00
NET ASSET BALANCE	$0.00	☐	$0.00

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 death benefits. _____

MONTHLY INCOME

	APPLICANT	CO-APPLICANT
Social Security	$	$
Private Pension	$	$
a. surviving spouse benefit / percentage?	0.00% %	0.00% %
b. cost of living increases?	☐ Yes ☐ No	☐ Yes ☐ No
Traditional IRAs/401K	$	$
Roth IRAs	$	$
Annuities	$	$
Installment Notes	$	$
Rental Income	$	$
Dividend Income	$	$
Interest Income	$	$
Other (attach schedule)	$	$
TOTAL MONTHLY INCOME	$ 0.00	$ 0.00

MONTHLY EXPENSES (Anticipated expenses at Twin Lakes NOT including monthly maintenance fee.)

Estimated monthly living expenses (such as food, car, entertainment, personal items, additional utilities)	$	$
Estimated monthly medical expenses (including prescription medications,copay/deductible payments, etc.)	$	$
Monthly insurance payments; *do not include LTC premiums* (including health, life, personal property, auto)	$	$
Family Support/Alimony*	$	$
TOTAL MONTHLY EXPENSES	$ 0.00	$ 0.00

*Please list any support you provide, whether or not you are legally obligated to provide the support.

INSURANCE

APPLICANT

Traditional Medicare Part A ☑ Yes ☐ No

Replacement or Advantage Medicare Plan ☐ Yes ☐ No

If Yes, Name of Company_____

Supplemental/Extended Ins. ☐ Yes ☐ No

If Yes, Name of Company_____

Long-term Care?_____ Annual Premium_____

Benefit Period_____ Daily Benefit_____

Elimination Period_____ Inflation Adj._____

Company Name_____

Applicant Signature_____

Date_____

CO-APPLICANT

Traditional Medicare Part A ☐ Yes ☐ No

Replacement or Advantage Medicare Plan ☐ Yes ☐ No

If Yes, Name of Company_____

Supplemental/Extended Ins. ☐ Yes ☐ No

If Yes, Name of Company_____

Long-term Care?_____ Annual Premium_____

Benefit Period_____ Daily Benefit_____

Elimination Period_____ Inflation Adj._____

Company Name_____

Applicant Signature_____

Date_____

I certify that the foregoing information is a true and complete statement of facts regarding my financial status as known to me. I agree to provide any additional information that Twin Lakes Community may reasonably require. I understand that if accepted for residency, I will not transfer or reduce resources necessary to fulfill my commitment. I understand that if any information contained in the application is materially inaccurate or incomplete, my residency agreement may be subject to cancellation.

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)

[ ] Tuberculosis
[ ] Cancer
[ ] Substance Abuse/Alcoholism
[ ] Mental Illness
[ ] Heart Disease or History of Heart Attack
[ ] Stroke
[ ] Kidney Failure/Dialysis
[ ] Diabetes
[ ] Parkinson's or Other Neurological Disorders
[ ] Difficulty Breathing
[ ] Memory Difficulties
[ ] Difficulty Ambulating
[ ] Glaucoma or Macular Degeneration
[ ] Incontinence of Bowel or Bladder
[ ] Spinal Stenosis
[ ] Chronic Pain
[ ] Circulatory Problems or Swelling in Feet or Legs

Have you ever been hospitalized for any of the above? If so, please describe:

_____

_____

5. Do you use any of the following equipment?

[ ] Wheelchair
[ ] Walker
[ ] Cane
[ ] Power Chair/Scooter
[ ] Oxygen
[ ] Hoyer Lift
[ ] In Home Dialysis Equipment
[ ] Feeding Tube

6. Describe in detail any mental illnesses, memory loss or substance abuse/alcoholism you have experienced. Please specify diagnosis, date of onset, and current status:

_____

_____

7. Do you smoke? [ ] Yes [ ] No

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

8. Describe any past surgical operations, serious illnesses or hospitalizations not previously mentioned. Please give dates and details:

_____

_____

9. Please describe any mobility limitations:

_____

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 _____ Phone _____

Address _____

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-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.

CO-APPLICANT INFORMATION:

1. Co-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)

- [ ] Tuberculosis
- [ ] Cancer
- [ ] Substance Abuse/Alcoholism
- [ ] Mental Illness
- [ ] Heart Disease or History of Heart Attack
- [ ] Stroke
- [ ] Kidney Failure/Dialysis
- [ ] Diabetes
- [ ] Parkinson's or Other Neurological Disorders
- [ ] Difficulty Breathing
- [ ] Memory Difficulties
- [ ] Difficulty Ambulating
- [ ] Glaucoma or Macular Degeneration
- [ ] Incontinence of Bowel or Bladder
- [ ] Spinal Stenosis
- [ ] Chronic Pain
- [ ] Circulatory Problems or Swelling in Feet or Legs

Have you ever been hospitalized for any of the above? If so, please describe:

_____

_____

5. Do you use any of the following equipment?

- [ ] Wheelchair
- [ ] Walker
- [ ] Cane
- [ ] Power Chair/Scooter
- [ ] Oxygen
- [ ] Hoyer Lift
- [ ] In Home Dialysis Equipment
- [ ] Feeding Tube

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_____

_____

7. Do you smoke? [ ] Yes [ ] No

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_____

_____

9. Please describe any mobility limitations:

_____

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 _____ Phone _____

Address _____

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 co-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 _____ Co-Applicant Signature _____