



ASSISTED LIVING APPLICATION PACKET

Complete and return this
Application to Edenton.

For questions regarding your application or move-in,
please contact:

Jennifer Minnick

Phone: 301-694-3100

Fax: 301-694-0308

JMinnick@edentonfrederick.com

We have been serving Frederick County
Seniors and their Families since 1989...

Discover Life at Edenton!

EDENTON 
RETIREMENT COMMUNITY

Independent • Assisted Living • Memory Care • Home Care

5800 Genesis Lane ~ Frederick, MD 21703

www.edentonfrederick.com

APPLICATION FOR ASSISTED LIVING

Name _____ Target Move-In Date: _____
Current Address _____
City _____ State _____ Zip Code _____
Home Phone Number _____ Date of Birth _____
Cell Phone Number _____ Email: _____
Physicians Name _____ Telephone _____
Number _____

If Resident has executed a Power of Attorney or if a Guardian has been appointed for a Resident, copies of Powers of Attorney or Guardianship Decrees must be provided to Provider **prior** to admission of the Resident, and copies of Advanced Directives and DNR/MOLST forms prior to or at admission.

Power of Attorney Financial No Yes Whom: _____ Phone: _____
Healthcare No Yes Whom: _____ Phone: _____

Advanced Directives No Yes **DNR/MOLST Form** No Yes

Guardianship No Yes Whom/Telephone _____

Any arrangement (financial, religious, name of preferred funeral Director, if any) the resident has made, or wishes to make with regard to burial. (State regulations require we maintain this information in file.)

Name _____ Phone _____
Address _____

Relationship of person who agrees to assume custody of the resident should resident pass away and assume funeral or burial responsibility. (State regulations require we maintain this information in file.)

Name _____ Relationship _____
Address _____

In Case of Emergency Contact:

Name _____ Relationship _____
Address _____ Home Phone _____
City/State/Zip _____ Cell Phone _____
Email: _____

Name _____ Relationship _____
Address _____ Home Phone _____
City/State/Zip _____ Cell Phone _____
Email: _____

List All Medical Diagnosis _____

List Current Medications (Please attach a copy of a current medication list complete with medication name, dosage, frequency and route i.e., oral, topical or IV and prescribing physician name and telephone number, including OTCs)

List any allergies _____

List dietary concerns _____

Appetite: good _____ fair _____ poor _____

Favorite Foods/Desserts _____

Any specific behaviors or cues to define a personal need? _____

Functional Status:	Self	Assist	Total	Specify
Feeding				
Bathing				
Toileting				
Oral Care				
Walking				

Elimination:

Bladder Continent _____ Incontinent _____ Special Cueing _____
Bowel Continent _____ Incontinent _____ Special Cueing _____

Communication Deficits: Hearing _____ Vision _____ Speech _____ Language _____

Prosthesis: Glasses _____ Contacts _____ Hearing Aid _____ Dentures _____ Limb _____

Family History:

Where was individual born? _____

Where did they grow up? _____

Education: _____

Work History: _____

Relationship Status: Single _____ Married _____ Widow _____ Domestic Partner _____ Other _____

Family and Friends Information

Resident Hobbies (past or present):

- Physical Activities Games Crafts Art Spiritual Affiliation _____
- Intellectual Sports Social/Cultural Music-type _____ Other

Resident Likes: _____

Resident Dislikes: _____

If the resident is not from the area, who can we contact that knows them well?

Name _____ Relationship _____

Phone _____ Email _____@_____

Resident or the Resident's legally authorized representative hereby authorizes healthcare providers to release to Administration at Edenton any and all health care information requested by resident making application. This authorization shall be in effect for one (1) calendar year from the date that appears below. In addition, Resident or Resident's legally authorized representative hereby consents to independent evaluation of Resident by any provider designated by Edenton at its sole discretion at Resident's and Guarantor(s)' sole expenses.

Signature _____ Date _____

FINANCIAL STATEMENT

Name _____ Social Security # _____
 Co-Applicant _____ Social Security # _____
 Current Address _____
 City _____ State _____ Zip Code _____
 Telephone Number _____ Email Address: _____ @ _____
 Social Security Number: _____ Marital Status: Married Widow Single Other

Landlord/Mortgage Co. Name _____
 Address _____
 Phone _____

Name(s) of person(s) who are financially responsible for cost of housing and care _____
 Address _____
 Home Phone _____ Cell/Work Phone _____
 Social Security _____ Relationship _____

Has a trust account been established and/or Power of Attorney or Guardianship conferred on the person(s) to be financially responsible? Yes _____ No _____ Whom _____

Note: If Resident has executed a Power of Attorney or if a Guardian has been appointed for the Resident, copies of Powers of Attorney or Guardianship Decrees must be provided to Provider prior to admission of the Resident.

Monthly Income		Assets (current balance of	
Social Security Benefits	\$	Savings Account(s)	\$
Retirement/Pension (source)	\$	Checking Account(s)	\$
	\$	Stocks	\$
Other (source)	\$	Bonds	\$
	\$	C.D.'s	\$
	\$	Other (describe)	\$
Annual Rental Income	\$		\$
Liabilities (describe)	\$		\$
	\$		\$
	\$		\$
Residence (if you own)	\$		\$
Value (approximate)	\$		\$
Mortgage (approximate)	\$		\$

I hereby authorize release of any and all information regarding Resident's finances to Edenton Retirement Community. Initial _____

I certify that the above information is accurate to the best of my knowledge and that it is representative only of the prospective resident.

 Resident or Legally Authorized Representative

Date _____

CREDIT REPORT AUTHORIZATION

Date: _____

Applicant's Name: _____

Address _____

Social Security No. _____ Date of Birth: _____

Co-Applicant's Name: _____

Co-Applicant Address _____

Co-Applicant's Social Security No. _____ Co-Applicant Date of Birth: _____

I/We hereby authorize CBF Business Solutions, Inc. or it's agent, to furnish to Edenton any information it requests to complete my credit worthiness.

Applicant Signature

Co-Applicant Signature

To: CBF

Fax 1-301-662-9196

Please process this request for a credit check and fax back to 301-694-0308. Please contact our main office with any questions or concerns at 301-694-3100.

Edenton Representative

Date

RESERVATION / WAIT LIST CONFIRMATION

I, _____, hereby request to place a deposit to RESERVE and/or ADD TO THE WAIT LIST for resident: _____

- | | | | |
|--------------------------|-----------------|-----------------|--------------|
| <input type="checkbox"/> | Blossom Place | Assisted Living | Unit # _____ |
| <input type="checkbox"/> | Fiddler's Green | Assisted Living | Unit # _____ |
| <input type="checkbox"/> | Garden House | Assisted Living | Unit # _____ |
| <input type="checkbox"/> | Orchard Terrace | Assisted Living | Unit # _____ |

I understand that the deposit of \$1,000.00 is fully refundable should the length of wait time exceed my moving needs, my personal needs change before an apartment/cottage becomes available or if a nursing assessment deems my individual needs cannot be appropriately met at Edenton.

When the apartment/cottage of my choosing becomes available and meets with my time frame for moving, I will have 7 days in which to begin paying on the apartment or take occupancy. If I am unable to take occupancy, I will be placed on the wait list for the next available unit. This deposit will be applied to the first month's fees. If my deposit is for a specific unit, I understand that I have 7 days to take financial possession of that unit or it will be released to the next person on the waiting list.

Prospective Resident/Responsible party

Date

Edenton Representative ~ Jennifer Holmes

Date

Date reserved _____ Check number _____ Check amount \$1,000.00
Copy of check:

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I authorize _____ to release to Edenton Retirement Community (“Provider”) such medical records and related information as Provider requests, for the purpose of providing medical care and treatment, concerning: (Patient) _____
(Date of Birth) _____

Any restriction that I wish to impose on this authorization is listed below:

I understand that Provider will not refuse to provide care to me if I refuse to sign this Authorization.

I have the right to so refuse.

I understand that I have the right to revoke this authorization.

Name of Resident (Printed)

Signature of Resident (or legally responsible individual)

Date

Witness

Date



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