



# ASSISTED LIVING APPLICATION PACKET

Complete and return this  
Application to Edenton.

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

Phone: 301-694-3100  
Fax: 301-694-0308  
[rbutler@edenton-retirement.com](mailto:rbutler@edenton-retirement.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](http://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

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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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