# INDEPENDENT LIVING APPLICATION PACKET

Complete and return this Application to Edenton.

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

rbutler@edentonfrederick.com

Phone: 301-694-3100
Fax: 301-694-0308

Discover Life at Edenton!

EDENTON
FREDERICK

5800 Genesis Lane ~ Frederick, MD 21703
www.edentonfrederick.com

# APPLICATION FOR INDEPENDENT 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)**: (basic information only; another form requests more details)

○ Physical Activities ○ Games ○ Crafts ○ Art ○ Spiritual ○ Intellectual ○ Sports
○ Social/Cultural ○ Music-type_____ ○Other

**Resident Likes:** _____

**Resident Dislikes:** _____

If the resident is coming from out of town, who would be a contact person that has been close to he/she?

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 its 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: _____

☑ Edenton Cottage Independent 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 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) _____(Birth date).

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