

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICATION FOR ADMISSION**

**PROGRAM** (Check One) \_\_\_\_\_ Independent Living (IL) \_\_\_\_\_ Assisted Living (AL)

 \_\_\_\_\_ Choices for Independence (CFI) \_\_\_\_\_ Memory Care (MC)

**GENERAL INFORMATION**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACTS**

Primary Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INFORMATION**

Health Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does applicant have a current and activated Durable Power of Attorney for Healthcare? \_\_\_\_\_\_\_\_\_\_

Does applicant have a Living Will? \_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL INFORMATION**

Does applicant manage their own finances? \_\_\_\_\_\_\_ Does the applicant have a POA? \_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Night Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does applicant have Long Term Insurance? \_\_\_\_\_\_ If yes, insurer’ name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CASH ASSETS:

Bank Name & Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Checking Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Balance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Savings Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Balance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certificate of Deposit # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Balance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stocks & Bonds Current Valuation $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicant owns a home, what is the Current Valuation? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicant owns other property, what is the Current Valuation? $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the type of any assets applicant has disposed of at less than market value in the last two years.

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Value: $ \_\_\_\_\_\_\_\_\_

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Value: $ \_\_\_\_\_\_\_\_\_

MONTHLY INCOME

Social Security $\_\_\_\_\_\_\_\_\_\_\_ Pension $\_\_\_\_\_\_\_\_ Disability $\_\_\_\_\_\_\_\_\_\_\_

Interest/Dividends $\_\_\_\_\_\_\_\_\_\_\_ Annuity $\_\_\_\_\_\_\_\_ Life Ins $\_\_\_\_\_\_\_\_\_\_\_\_

Rental Income $\_\_\_\_\_\_\_\_\_\_\_ Other $\_\_\_\_\_\_\_\_

TOTAL MONTHLY INCOME $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Current or prior occupations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies and Special Interests \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religious Affiliations (Optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Group Affiliations – past and present \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Childhood Hometown \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Higher Education Schools & Program of Study \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL CHARACTERISTICS**

Does applicant have need for an accessible/barrier free apartment? Yes \_ No \_\_\_\_\_\_\_\_

YES or NO? Walks unassisted? \_\_\_\_\_\_\_\_ Uses a cane? \_\_\_\_\_\_\_\_ Uses a walker? \_\_\_\_\_\_\_\_\_

Uses a wheelchair? If yes, can applicant transfer unassisted? \_\_\_\_\_\_\_\_\_

ABILITIES: Please put a CHECK MARK under the appropriate term

TASK Independent Needs some assistance Total Assist \_\_\_\_

Grooming/Shaving \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dressing \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bathing \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mouth/Skin Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toileting \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Mgt \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Escort/Mobility \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Housekeeping \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clothing Mgt \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other daily needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES or NO? Is applicant alert? \_\_ Oriented to time/place? \_\_ Forgetful? \_\_\_\_

 Anxious? \_\_\_\_\_\_\_ Confused? \_\_\_\_\_\_\_\_

Does applicant have any allergies including reactions to drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes, please provide details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICATION FEE**

*Summercrest Assisted Living, LLC charges a onetime, application fee of $500.00 (see fee schedule) to process applications for all permanent living programs except the Choices for Independence program. Included in this fee is the cost of the mandatory health assessment of the prospective resident, which is conducted by Summercrest personnel. Please submit a check made payable to Summercrest along with this application.*

*\*Per state regulation applicants to CFI program are exempt from application fee. Application fee not applicable for respite residents.*

**RELEASE OF INFORMATION**

*I understand and agree that this application is neither a contract nor a reservation for residency. Nothing contained in this document is legally binding on either Summercrest or me until a Residency Agreement (Lease) has been signed and approved by both parties. In addition, acceptance for admission does not constitute acceptance into the Choices for Independence (formerly named Home and Community Based Care) program, which may have separate criteria for admission.*

*I certify that the information I have given in this application is true and correct. Summercrest is required to verify the income and assets for all applicants to the CFI program prior to acceptance and admission. I understand that any false statements or misrepresentations or omissions may result in the cancellation of my application or nullification of my residency agreement.*

 *I authorize Summercrest to conduct a review of my financial status and obtain information necessary to verify my ability to pay for residency. I further agree to notify Summercrest in writing of any substantial change in my (applicant’s) financial or medical condition.*

*I give permission to Summercrest and its contracted home care agency (Lake Sunapee Region VNA) to request and receive health information from my physicians and/or medical facilities where I received treatment in the last three years. This information will be used in a health assessment prior to admission. Summercrest and LSRVNA agree to keep this information strictly confidential.*

Applicant’s Signature \_\_\_\_\_ Date

*If someone other than the applicant is completing this form for residency, please print the name of the person completing the information, state the relationship to the applicant, sign and date below.*

[Please attach a copy of the Power of Attorney or other document authorizing a person to act on the applicant’s behalf.]

Name \_\_\_\_\_ Relationship

Signature \_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

PLEASE PROVIDE THE FOLLOWING DOCUMENTS WHEN SUBMITTING APPLICATION:

1. Photo ID
2. Copy of one of the following -- Birth Certificate, Baptismal Certificate or Passport
3. Copy of Social Security Card
4. Copy of Medicare Card
5. Copies of Health Insurance Cards including Medicare Parts B, C & D
6. Copy of LTC Insurance Card, if Applicable
7. Copy of Power of Attorney Document
8. Copy of Power of Attorney for Health Care
9. Copy of Living Will