THE COMMUNITY AT
ROCKHILL

FOR INTERNAL USE

Application Received _____ Deposit Received _____ Admission Date _____

❑ PC ❑ HC Room # _____ Private Phone Number _____

PERSONAL OR HEALTH CARE CENTER APPLICATION FOR ADMISSION

Please check the level of care for which you are applying: ❑ Personal Care Center ❑ Health Care Center

Last Name _____ First Name _____

Middle _____ Social Security # _____ Gender: ❑ M ❑ F

Date of Birth _____ Age _____ Place of Birth _____

Prefers to be called _____ Primary Language Spoken _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Mobile Phone _____

Email Address _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Widowed ❑ Divorced

Spouse's Name _____

Referred by _____

Your occupation, trade, or profession _____

Are you employed? ❑ Yes ❑ No Where? _____

Education Completed: ❑ Elementary ❑ High School ❑ College ❑ Graduate School

Religious Affiliation _____

Citizen: ❑ Yes ❑ No Veteran: ❑ Yes ❑ No Living Will: ❑ Yes ❑ No (If yes, please attach)

Admitted From

Facility/Home/Other _____

Phone _____ Dates of Stay _____

Insurance

Medicare # _____ Medicaid Access # _____ Effective Date _____

Supplemental _____

Part D Coverage _____

Insurance Name (Other than Medicare/Medicaid) _____

Address _____ City _____

State _____ Zip Code _____ HMO/PPO ❑ Yes ❑ No Pre-Cert Req. ❑ Yes ❑ No

Policy Number _____ Group Number _____

Long-Term Insurance Company _____ # _____

Financial Statement (Part 1)

The Community at Rockhill is a nonprofit Life Plan Community (CCRC). It is dependent upon the income received from its residents, and is subsidized by gifts from individuals and organizations. It is necessary, therefore, that information is provided relative to your ability to pay the necessary charges over a period of time. All information will be kept strictly confidential. Please attach copies of your most recent tax return as well as your most recent statements verifying the assets listed in this application.

ASSETS	JOINT	APPLICANT	SPOUSE
Primary Residence (Current market value)			
Mortgage Balance			
Home Equity Lines of Credit			
Total Equity (Current market value minus loans)			
Name Under Which Residence is Deeded			
Other Real Estate (Current market value minus loans)			
Savings Account Balance			
Checking Account Balance			
Money Market Account Balance			
Certificate of Deposit Value			
Interest Rate	%	%	%
Stock Values			
Mutual Funds			
Bonds/Bond Funds			
IRA/401(k) Value			
Distribution Amount			
(PLEASE NOTE FREQUENCY) Monthly Quarterly Yearly			
Annuity Value			
Amount of Monthly Payment			
Trust Account Value			
Is this irrevocable? ❑ Yes ❑ No			
Is this available for your care? ❑ Yes ❑ No			
Life Insurance (Cash surrender value)			
Burial Reserve			
Other Assets (Please describe)			
Other Assets (Please describe)			

Financial Statement (Part 2)

MONTHLY INCOME	JOINT	APPLICANT	SPOUSE
Social Security			
Pension What portion will remain for your spouse in the event of your death?			
IRA/401(k) Distribution			
Regular Annuity Payments			
Other Income (Please describe)			
Other Income (Please describe)			

MONTHLY EXPENSES	JOINT	APPLICANT	SPOUSE
Insurance Premiums			
Auto			
Health			
Life			
Long-Term Care			
Medicare Part D			
Prescriptions			
Mortgage/Rent			
Other Expenses (Please describe)			
Other Expenses (Please describe)			

LONG-TERM CARE INSURANCE	*Example*	APPLICANT	SPOUSE
Benefit Period (Indicate number of years or record "L" for lifetime)	*4 years*		
Elimination Period (i.e., the number of days from 0 to 365 before benefit payments start)	*90 days*		
Daily Benefit for Assisted Living in Current Dollars	*$70.00*	$	$
Daily Benefit for Nursing Care in Current Dollars	*$120.00*	$	$
Does the policy include a benefit inflation adjustment rider?	*Yes*	❑ Yes ❑ No	❑ Yes ❑ No
If so, indicate the inflation amount	*3.0%*	%	%
Premium	*$200*	$	$
Number of Payments per Year	*12*	1 4 12	1 4 12
Assumed Inflation Rate on Premiums	*4.0%*	%	%

Financial Statement (Part 3)

Have you transferred or divested any asset not listed in part one of the Financial Statement with a value exceeding $10,000?
❑ Yes ❑ No (If yes, explain circumstances on an attached paper.)

Within the past five years, have you or your spouse closed, given away, sold, or transferred any assets such as a home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds, trust funds, or right to income? ❑ Yes ❑ No (If yes, explain circumstances on an attached paper.)

Do you have a prenuptial agreement spelling out the disposition of your assets? ❑ Yes ❑ No (If yes, explain circumstances on an attached paper.)

Has money been set aside for burial expenses? (The Community at Rockhill is not responsible for these expenses.) ❑ Yes ❑ No

Personal Information

Primary Care Physician _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Mobile _____ Fax _____

Preferred Hospital _____

Dentist Name _____

Office Phone _____ Mobile _____ Fax _____

Ophthalmologist Name _____

Office Phone _____ Mobile _____ Fax _____

Podiatrist Name _____

Office Phone _____ Mobile _____ Fax _____

Physical Information

Allergies (medications, food, environmental) _____

_____

_____

Do you smoke? ❑ Yes ❑ No Rockhill is a tobacco and smoke-free community. Will you comply with this policy? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How much? _____

Height _____ Weight _____ Do you wear dentures? ❑ Upper ❑ Lower ❑ Both

Pneumoccal vaccine received? ❑ Yes ❑ No If yes, date received _____

Diet _____

Tube Feeding

Type _____

Amount _____ Frequency _____

Ambulatory Status
- ❑ Independent
- ❑ Walks with assistance
- ❑ Help from bed to chair
- ❑ Bed bound

Assistive Device
- ❑ Cane
- ❑ Walker
- ❑ Wheelchair
- ❑ Brace

Bathing
- ❑ Independent
- ❑ Bathing with help
- ❑ Bed bath with help
- ❑ Bed bath

Communication Barrier

❑ Yes ❑ No

Describe _____

_____

_____

Dressing
- ❑ Independent
- ❑ Help with dressing
- ❑ Cannot dress self

Elimination
- ❑ Independent
- ❑ Help to bathroom
- ❑ Bedpan/urinal required
- ❑ Incontinent
- ❑ Foley
- ❑ Ostomy

Feeding
- ❑ Independent
- ❑ Help with feeding
- ❑ Cannot feed self

Hearing
- ❑ Normal
- ❑ Impaired
- ❑ Deaf

Hearing Aid

❑ Left ❑ Right

Mental Health
- ❑ Alert and oriented
- ❑ Confused at times
- ❑ Special emotional needs

Oxygen Use

❑ Yes ❑ No

Describe _____

_____

Routines

Check all that apply
- ❑ In bedclothes most of the day
- ❑ Has irregular bowel movement pattern
- ❑ Showers for bathing
- ❑ Bathing in PM
- ❑ Daily contact with relatives/close friends

Sight
- ❑ Normal
- ❑ Impaired
- ❑ Blind
- ❑ Glasses
- ❑ Contact lens
- ❑ False eye

Skin
- ❑ Intact
- ❑ Wounds or dressings

Describe _____

_____

_____

Speech
- ❑ Normal
- ❑ Impaired
- ❑ Unable to speak

Please list any on-going treatment in the past six months _____

_____

Please list any other facilities admitted to in the past six months _____

_____

Does applicant have increased confusion at night? ❑ Yes ❑ No If yes, please describe _____

_____

Does applicant wander? ❑ Yes ❑ No If yes, please describe _____

_____

Is applicant cooperative? ❑ Yes ❑ No If yes, please describe _____

_____

Please list all medications the applicant is currently taking.

Medication Name	Dosage	Frequency	Time Given

Has the applicant been diagnosed with or experienced any of the following conditions? Check all that apply.

- ❑ Allergies
- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Antibiotic Resistant Infection (e.g. Methicillin resistant staph)
- ❑ Anxiety Disorder
- ❑ Aphasia
- ❑ Arterisclerotic Heart Disease (ASHD)
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Cardian Dysrhythmias
- ❑ Cataracts
- ❑ Cerebral Palsy
- ❑ Cerebrovascular Accident (stroke)
- ❑ Clostridium Difficile (c.diff.)
- ❑ Congestive Heart Failure
- ❑ Deep Vein Thrombosis
- ❑ Dementia other than Alzheimer's Disease
- ❑ Depression
- ❑ Diabetes Mellitus
- ❑ Diabetic Reinopathy/ Neoropathy
- ❑ Emphysema/COPD
- ❑ Glaucoma
- ❑ Hepatitis
- ❑ Hip Fracture
- ❑ HIV Infection
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypotension
- ❑ Hypothyroidism
- ❑ Macular Degeneration
- ❑ Missing Limb (e.g. amputation)
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Other Cardiovascular Disease
- ❑ Paralysis
- ❑ Parkinson's Disease
- ❑ Pathological Bone Fracture
- ❑ Peripheral Vascular Disease
- ❑ Pneumonia
- ❑ Psychiatric Disorder
- ❑ Renal Failure
- ❑ Respiratory Infection
- ❑ Seizure Disorder
- ❑ Septicemia
- ❑ Sexually Transmitted Diseases
- ❑ Transient Ischemic Attack (TIA)
- ❑ Tuberculosis
- ❑ Urinary Tract Infection lasting >30 days
- ❑ Wound Infection

Mail Delivery

Check one: ❑ All mail to resident ❑ Personal mail only

If personal mail only, forward first class mail to _____

Address _____

City _____ State _____ Zip Code _____

Contact Information

Please list in priority order

Name #1 _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Power of Attorney Type: ❑ Health Care ❑ Financial ❑ Neither

Name #2 _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Power of Attorney Type: ❑ Health Care ❑ Financial ❑ Neither

Are there additional family members or important contacts who should receive updates and information from the Community at Rockhill? Please list their contact information below. If you need additional space, simply attach the information to this application.

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Contact Information (continued)

Person responsible for monthly invoices if different from applicant

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Trust Officer or person responsible for financial affairs

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Durable Power of Attorney – Finances

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Durable Power of Attorney – Medical

Name _____ Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

Do you have a Living Will or Advance Directive? ❑ Yes ❑ Not Presently

Executor - as listed in Will

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Email Address _____

Have funeral arrangements been made? ❑ Yes ❑ No

If not, who is to make these arrangements? _____

If yes, where have they been arranged?

Funeral Home _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Personal Information

Is there anything else you feel we need to know about the applicant? _____

List any relatives or friends who live at the Community at Rockhill or have lived here in the past _____

_____

Please list your hobbies, activities, and interests _____

How did you learn about the Community at Rockhill? _____

Megan's Law

The Community at Rockhill (Community) is committed to providing a safe living environment for our residents and staff. It is the policy of the Community to screen all incoming potential Residential Living, Personal Care, and Health Care residents against the applicable Megan's Law websites. Adult Day Services clients will also be screened. The Community reserves the right to deny admission to anyone found listed on the Megan's Law websites. By signing below, I acknowledge that I am not required to register under any Federal or State "Megan's Law" statute, or have registered, if required to do so under any of the same statutes.

FOR INTERNAL USE

Screen Completed _____

Documentation Attached _____

Date _____

Initials _____

APPLICANT Signature _____ Date _____

Agreement

All of the assets listed in this application as owned or controlled by me (us) are titled or registered in my (our) individual or joint names, or held for my (our) benefit, and are available to pay for all levels of care at the Community at Rockhill. I (We) have full power and authority to convey or utilize such assets for my (our) personal support and for payment for services supplied through the Community at Rockhill. I (We) grant permission to verify any information contained in this financial disclosure. I (We) authorize the Community at Rockhill to obtain my (our) financial records from the financial institutions or other institutions identified on this application and agree to execute any releases requested by the Community at Rockhill, and I (we) hereby authorize any such financial or other institutions to release to the Community at Rockhill any information or documentation that may be requested by the Community at Rockhill. I (We) affirm that I (we) (or my/our agent(s)) will not deplete nor jeopardize such assets below the level of that reasonably required to provide for my (our) care. I (We) acknowledge that if I (we) jeopardize my (our) ability to pay for my (our) care, then I (we) may be ineligible for admission to any level of care at the Community at Rockhill and may be ineligible for financial assistance from the Community at Rockhill. I (We) understand and acknowledge that the Community at Rockhill relies on the information and disclosures made in this application for the purpose of inducing the Community at Rockhill to consider me (us) for admission. I (We) certify that the information and disclosures provided in this application are true, correct, and complete to the best of my (our) knowledge and belief. Should any of the assets disclosed change significantly by will, sale, gift, or any other means, I (we) agree to notify the Board of Directors of the Community at Rockhill within thirty (30) days.

I (We) understand that my (our) submission of application for residency to the Community at Rockhill is not binding since my (our) physical, mental or financial situation may change prior to my (our) ability to reside at the Community. The final approval of this application is subject to review and decision of the Administration and Board of Directors of the Community at Rockhill.

APPLICANT Signature _____ Date _____

SPOUSE Signature (if applicable) _____ Date _____

WITNESS Signature _____ Date _____

WITNESS Relationship _____

Person completing this form other than the Applicant

Name _____

Signature _____ Date _____

Relationship to Applicant _____

Make checks payable to "The Community at Rockhill."