Summercrest
A Senior Living Community

ADMISSION APPLICATION

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 _____

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FINANCIAL INFORMATION

Does applicant manage their own finances? _____
If no, please provide the following information about the responsible person or company.

Name _____ Relationship _____

Address _____

Day Phone _____ Night Phone _____ Email _____

Does applicant have a Power of Attorney (POA)? _____ If yes, please name the individual.

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, non-refundable application fee of $500.00 (see fee schedule) to process applications for all 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.*

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 (Connecticut Valley Home Care) 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 CVHC 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
7. Copy of Power of Attorney Document
8. Copy of Power of Attorney for Health Care
9. Copy of Living Will