

# **EDENTON RETIREMENT COMMUNITY**

## **RESERVATION & APPLICATION**

### **PACKET**

#### **ORCHARD TERRACE**

#### **OPENING SUMMER 2012**

**Edenton Retirement Community**

**5800 Genesis Lane**

**Frederick, MD 21703**

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

**website: [www.edenton-retirement.com](http://www.edenton-retirement.com)**

**email: [cogden@edenton-retirement.com](mailto:cogden@edenton-retirement.com)**

We have been serving Frederick County for 22 years. With that much experience,

Edenton is more than a *Lifestyle of Convenience*, we are

***“A Great Place to Hang Your Hat!”***

Edenton Retirement Community

5800 Genesis Lane, Frederick, Maryland 21703

# APPLICATION

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Name \_\_\_\_\_  
Current  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_  
Telephone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
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.

Power of Attorney  
No \_\_\_\_\_ Yes \_\_\_\_\_ Whom \_\_\_\_\_  
Guardianship  
No \_\_\_\_\_ Yes \_\_\_\_\_ Whom \_\_\_\_\_

Any arrangement (financial, religious, name of preferred funeral Director, if any) the resident has made, or wishes to make with regard to burial.

Name \_\_\_\_\_  
Address \_\_\_\_\_

Relationship of person who agrees to claim the body of the resident, or who has agreed to assume funeral or burial responsibility.

Name \_\_\_\_\_  
Address \_\_\_\_\_

In Case of Emergency Contact:

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

**List All Medical** (Please attach a list of all current medications)

Diagnosis \_\_\_\_\_

**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				

**Prosthesis:**

Glasses \_\_\_\_\_ Contacts \_\_\_\_\_ Hearing Aid \_\_\_\_\_ Dentures \_\_\_\_\_ Limb \_\_\_\_\_

**Family History:**

Where was individual born? \_\_\_\_\_

Where did they grow up? \_\_\_\_\_

Education: \_\_\_\_\_

Work History: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widow \_\_\_\_\_ Other \_\_\_\_\_

**Children/Grandchildren**

Names, Addresses & Ages:

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**Resident Hobbies:**

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**Resident Likes:**

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Resident Dislikes:

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What Types of Music Resident Likes:

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

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

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 \_\_\_\_\_

Edenton Retirement Community  
5800 Genesis Lane Frederick, MD 21703

**FINANCIAL STATEMENT**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Co-Applicant \_\_\_\_\_ Social Security # \_\_\_\_\_

Current Address \_\_\_\_\_

Landlord/Mortgage Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Name(s) of person(s) who are financially responsible for cost of housing and care \_\_\_\_\_

Address \_\_\_\_\_

Home & Office Phone \_\_\_\_\_

Social Security \_\_\_\_\_

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.

<u>Monthly Income</u>		<u>Assets (current balance of</u>	
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

EDENTON  
RETIREMENT COMMUNITY

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

RE: CREDIT REPORT AUTHORIZATION

Applicant's Name: \_\_\_\_\_

Address \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Co-Applicant's Name (if applicable): \_\_\_\_\_

Address \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize CBF Business Solutions, Inc. or it's agent, to furnish to Edenton any information it requests to complete my credit worthiness.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Co-Applicant's Signature

Information As Of: \_\_\_\_\_  
Move-In Date: \_\_\_\_\_

**Edenton Retirement Community**  
5800 Genesis Lane \* Frederick, MD 21703  
Telephone: 301-694-3100 Fax: 301-694-0745  
Security:301-663-5337

## **EMERGENCY CONTACT SHEET**

Resident's Name: \_\_\_\_\_

Address at \_\_\_\_\_ Apt No. \_\_\_\_\_  
Edenton: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security \_\_\_\_\_  
Number: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

### **In Case of Emergency Contact**

#1 Name/Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_  
Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Cell Telephone \_\_\_\_\_ Email: \_\_\_\_\_

#2 Name/Relationship \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work \_\_\_\_\_  
Cell Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Email: \_\_\_\_\_

Primary Insurance		Policy #	
Secondary Insurance		Policy #	
Prescription Insurance		Policy #	
Primary Pharmacy		Back up	



## ORCHARD TERRACE WAIT LIST CONFIRMATION

I, \_\_\_\_\_, hereby request to add my  
name (s) to the wait list for: \_\_\_\_\_  
(Name of person(s) moving)

- Orchard Terrace      Assisted Living
- Studio
- Companion Suite
- One bedroom Suite
- Couple's Suite

I understand that the deposit of 1000.00 is fully refundable should my needs change prior to Orchard Terrace Assisted Living opening and my unit becoming available.

Orchard Terrace is scheduled to open for business July of 2012. Upon receiving notification that Orchard Terrace has been authorized to open, it is my understanding that I will be contacted by the Community Relations team to schedule a move in date that will take place within 30-45 days of that date.

Should I not be ready to take possession of the unit within that time frame, I understand that I will lose my current position on the waiting list and another wait list applicant will be offered my unit.

This deposit will be applied to the first month's fees.

\_\_\_\_\_  
Prospective Resident/Responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Edenton Representative

\_\_\_\_\_  
Date

Date reserved \_\_\_\_\_

Check number \_\_\_\_\_

Check amount \_\_\_\_\_



**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).

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

\_\_\_\_\_  
Signature of Resident (or legally responsible individual)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date