

APPLICANT'S HEALTH HISTORY

See page 3 for co-applicant's health history form

Applicant Name _____

Describe the general condition of your health: _____

Please indicate any existing or previous condition(s):

- | | |
|--|--|
| <input type="checkbox"/> Liver disease (including hepatitis, cirrhosis) | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lung disease (asthma, emphysema, TB, chronic bronchitis) | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer (including leukemia) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neurological diseases (including Alzheimers, Parkinson's, MS, etc.) | <input type="checkbox"/> Eye disease |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Emotional or psychiatric | <input type="checkbox"/> Heart conditions |
| <input type="checkbox"/> Stroke or TIAs | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Use of assistive device or need help walking | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Alcoholism or drug addiction | <input type="checkbox"/> Kidney disease |

Other (please explain): _____

What medications are you currently taking? _____

Surgeries in the last five years: _____

Do you need assistance in activities of daily living (bathing, dressing, taking medication)? Yes No

Please provide information about the primary care physician who will prepare your 60-day Medical

Verification Form prior to occupancy: Name _____

Phone _____ Email _____

Address _____

City _____ State/Zip _____

Do you authorize the Admission Review Committee to discuss your health with the above physician?

Yes No

Other physicians who provide care for you:

Name	Discipline	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONFIDENTIAL FINANCIAL DISCLOSURE FOR _____

CURRENT ASSETS

Applicant

Co-applicant (if held separately)

Checking account.....	_____	_____
Savings account	_____	_____
Stocks.....	_____	_____
Bonds.....	_____	_____
CDs	_____	_____
Annuities	_____	_____
Home value.....	_____	_____
Other real estate.....	_____	_____
Life insurance with spouse as beneficiary	_____	_____
Trust Funds.....	_____	_____
Other assets (please explain)	_____	_____
.....	_____	_____
OR Value of portfolio	_____	_____
(please include copy or copies of most recent statements)		

TOTAL ASSETS

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LIABILITIES

Mortgage.....	_____	_____
Notes payable	_____	_____
Bills due	_____	_____
Other (please explain).....	_____	_____
.....	_____	_____

TOTAL LIABILITIES

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NET ASSETS

--

If any funds are in trust, may the principal be used for your expenses if needed? Yes No

If married, indicate with a star (*) any assets that will NOT be available to your spouse upon your death.

CONFIDENTIAL FINANCIAL DISCLOSURE FOR _____

MONTHLY INCOME

Applicant

Co-applicant (if held separately)

Social Security	_____	_____
Pension	_____	_____
Interest	_____	_____
Dividend	_____	_____
Rental income.....	_____	_____
Annuity.....	_____	_____
IRA	_____	_____
Trust fund.....	_____	_____
Income from notes receivable	_____	_____
Other (please explain)	_____	_____
.....	_____	_____

TOTAL MONTHLY INCOME

Note: Please list any pertinent information regarding expiration dates on the above sources of income. Explain if pension and annuity plans include survivor benefits and indicate amounts or percentages.

ESTIMATED MONTHLY EXPENSES

Applicant

Co-applicant (if purchased separately)

Auto(s)	_____	_____
Medical	_____	_____
Insurance	_____	_____
Gifts/Entertainment/Etc.....	_____	_____

Applicant Medicare # _____ Part A _____ Part B _____

Applicant supplemental insurance company _____ # _____

Co-applicant Medicare # _____ Part A _____ Part B _____

Co-applicant supplemental insurance company _____ # _____

Applicant long-term care insurance _____ Policy # _____

Daily reimbursement rate _____ Cost-of-living adjustment (if applicable) _____%

Co-applicant long-term care insurance _____ Policy # _____

Daily reimbursement rate _____ Cost-of-living adjustment (if applicable) _____%

Insert Side B

CO-APPLICANT'S HEALTH HISTORY

Co-applicant Name _____

Describe the general condition of your health: _____

Please indicate any existing or previous condition(s):

- | | |
|--|--|
| <input type="checkbox"/> Liver disease (including hepatitis, cirrhosis) | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lung disease (asthma, emphysema, TB, chronic bronchitis) | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer (including leukemia) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neurological diseases (including Alzheimers, Parkinson's, MS, etc.) | <input type="checkbox"/> Eye disease |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Emotional or psychiatric | <input type="checkbox"/> Heart conditions |
| <input type="checkbox"/> Stroke or TIAs | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Use of assistive device or need help walking | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Alcoholism or drug addiction | <input type="checkbox"/> Kidney disease |

Other (please explain): _____

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Phone _____ Email _____

Address _____

City _____ State/Zip _____

Do you authorize the Admission Review Committee to discuss your health with the above physician?

Yes No

Other physicians who provide care for you:

Name	Discipline	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL HISTORY FOR APPLICANT

Applicant Name _____

Place of birth _____

Where did you live most of your life? _____

Present or former occupation(s) _____

Education: _____

In what organizations (charitable, civic, social) are you (or have you been) involved? _____

Church affiliation: _____

What do you like to do in your spare time? _____

Are you a tobacco user? Yes No

Have you ever been charged with a felony? Yes No

If yes, details _____

PERSONAL HISTORY FOR CO-APPLICANT

Co-applicant Name _____

Place of birth _____

Where did you live most of your life? _____

Present or former occupation(s) _____

Education: _____

In what organizations (charitable, civic, social) are you (or have you been) involved? _____

Church affiliation: _____

What do you like to do in your spare time? _____

Are you a tobacco user? Yes No

Have you ever been charged with a felony? Yes No

If yes, details _____

As an applicant (and co-applicant) for residency at The Village at Brookwood, I attest that this is a true representation of my personal, health and financial information. I understand that any misrepresentation may be grounds for nullification of the Residence and Services Agreement.

Applicant's Signature _____ Date _____

Co-applicant's Signature _____ Date _____