THE PINES
AT • DAVIDSON

APPLICATION

Full Name: _____ Preferred Name: _____

Spouse/Partner: _____

Address: _____

Email: _____ Landline Telephone: _____

Cell Phone: _____

Date of Birth: _____ Place of Birth: _____

Gender: _____ | ☐ Married ☐ Widow ☐ Divorced ☐ Single | Years at Present Address: _____ ☐ Rent ☐ Own

Where have you lived most of your life? _____

Other places you have lived? _____

Have you ever been a resident of another retirement community? ☐ No ☐ Yes, how many years? _____

Background:

Education Background (school, degree, and field of study): _____

_____

_____

In what vocation or professions are/were you engaged? (Please note if you are currently working.)

_____

_____

In what volunteer community services are/were you engaged? (Please note if you are currently volunteering.)

_____

_____

What are your special interests, hobbies, or skills?

_____

_____

Name: _____

Please List Your Children:

Name: City/State: Telephone/Email:

1. _____
2. _____
3. _____
4. _____

Religion (optional):

Present Church Affiliation (Church Name): _____

Church City/State: _____

Denomination: _____

The section below only needs to be completed after an offer is made:

Do you presently have a person or firm handling your business affairs?:

☐ No ☐ Yes, Please name: _____

Address: _____

Telephone #: _____ Email: _____

Who is the executor of your estate or will?

Name: _____

Relation: _____

Address: _____

Telephone/email: _____

Name of funeral home, city and state: _____

Vehicle license number and state: _____ Handicap Placard: ☐ No ☐ Yes

Social Security Number: _____

Signature: _____

Date: _____

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CONFIDENTIAL FINANCIAL STATEMENT

☐ **Applying for Future Residency Program (☐Wait list ☐Ready list).**
Acceptance to the Future Residency Program does not guarantee acceptance to The Pines.

☐ **Applying for admission after an offer is made.**
Supporting documents must accompany this statement at the time an offer is made.

If married, only one form is needed

Applicant 1: _____ DOB: _____ Gender: _____ ☐ Single ☐ Married

Applicant 2: _____ DOB: _____ Gender: _____ ☐ Single ☐ Married

Email for financial questions: _____ Telephone: _____

Assets	Total	Right of Survivorship %
Total Real Estate Owned	$	
Stocks		
Bonds		
Mutual Funds		
CDs		
Savings		
Variable Annuities		
Other (Itemize)		
Other (Itemize)		
Other (Itemize)		
Other (Itemize)		
Total Assets	$	

Liabilities	Total
Mortgage Payable	$
Car Loan(s)	
Notes Payable to Banks/Others	
Other (Itemize)	
Other (Itemize)	
Total Liabilities	$

INITIAL HERE _____ _____ The total principal of all investments shown above will be available to meet my/our) financial/healthcare obligations until my/our death.

Schedule of Income (If more space is needed, please attach information.)

Income	Resident 1	Resident 2	Combined	Right of Survivorship %
Social Security	$ /month	$ /month	$ /month	
Pension	$ /month	$ /month	$ /month	
Fixed Annuities	$ /month	$ /month	$ /month	
Other (specify)	$ /month	$ /month	$ /month	
Other (specify)	$ /month	$ /month	$ /month	
Total Income	$ /month	$ /month	$ /month	

Name: _____

Real Estate Owned

Description of Property & Improvements	Title in Name of	Date Acquired	Cost	Market Value	Mortgage Amount	Interest Rate
			$	$	$	

Investments Owned (Stocks, Bonds, Mutual Funds, CDs, etc.)

Name of Financial Institution	Description/Type	In name of	Market Value

Schedule of Long-Term Care Insurance Carried (If we approve your financial application based on your long-term care insurance, we will require you to maintain the coverage while living at The Pines.)

Long-Term Care Insurance	Applicant 1	Applicant 2	Joint	
Monthly Premium	$	$	$	
Premium Inflation Rate %	%	%	%	
Benefit Period (Time Cap)	Months	Months	Months	
Coverage Pool (Dollar Cap)	$	$	$	
Elimination Period	Days	Days	Days	
Coverage-Assisted Living/Day	$	$	$	Inflation ____% Simple
Coverage-Skilled Living/Day	$	$	$	Inflation ____% Simple
Reimbursement Type	Expense	Expense	Expense	

Schedule of Life Insurance Carried (only if Applicant 1 or 2 are the beneficiaries)

Life Insurance	Applicant 1	Applicant 2
Name of Company		
Cash Surrender Value	$	$
Face Value	$	$
Loans Outstanding	$	$
Beneficiary		

Name of person having power-of-attorney over my financial affairs: _____

City: _____ State: _____ Telephone#: _____

Email: _____ Relationship: _____

I affirm that this information is correct and substancially complete to the best of my knowledge.

Signature Applicant 1: _____ Date: _____

Signature Applicant 2: _____ Date: _____

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PERSONAL HEALTH HISTORY

Name: _____

In your own words, briefly describe your physical, cognitive and emotional health: _____

_____

_____

_____

Specify any limitations you have or assistive devices you use (vision, hearing, memory, climbing steps, driving; use walker, wheelchair, oxygen, hearing aids, glasses/contacts, dentures):

_____

_____

Describe any allergies including reactions to any drugs/medications:

_____

_____

Describe major surgical operations, serious illness, diagnoses, hospitalizations, or major life events:

1. Year: _____ _____

2. Year: _____ _____

3. Year: _____ _____

4. Year: _____ _____

5. Year: _____ _____

6. Year: _____ _____

Are you presently under special medical care or seeing a specialist?: ☐ No ☐ Yes, describe: _____

_____

Have you ever been treated for depression, anxiety, or any other mental health conditions?: ☐No ☐Yes, describe:

_____

_____

Do you have or have you had the following: Name: _____

Tuberculosis	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Heart Attack or Heart Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Paralysis	☐ Yes	☐ No	Substance Use Disorder	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Mental Health Treatment	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Cognitive Changes	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No	Thoughts of Self Harm	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	If yes, what bones? _____					

Other: _____

Do you have a strict special diet?: ☐ No ☐ Yes, describe: _____

_____

Do you have any planned or upcoming surgeries or procedures? _____

Current Hospital/Healthcare Provider: _____

City/State:_____

Medicare Number: _____

Medicare Supplement Insurance Company: _____

Do you have other supplemental insurance?: ☐ No ☐ Yes _____

Physician(s)(Use additional page if needed)**:**

1. Name: _____
   Address:_____ Telephone #_____
2. Name: _____
   Address:_____ Telephone #_____
3. Name: _____
   Address:_____ Telephone #_____

Dentist(s):

Name: _____

Address:_____ Telephone #_____

In Case of Emergency, notify:

1. Name: _____
   Relationship:_____ Telephone#_____
   City/State_____

Additional Remarks or Clarifications: _____

_____

_____

Prescriptions/Over-the-Counter Medications/Supplements/Vaccinations: on a separate page, please list all items including strength, dose, frequency and prescribing doctor. You may also print this out from MyChart.

I declare the answers to be true, full and complete. Signature:_____