

We encourage you to visit the campus of your choice, talk to a representative and pick up an application.

If that's not convenient for you, please download and print the application. After you've filled it out, please mail it to the campus of your choice. The address is on the home page of the campus website. If you're considering more than one campus, send your application to:

Marketing  
Covenant Retirement Communities Inc.  
5700 Old Orchard Rd.  
Skokie IL 60077-1036

*Covenant Retirement Communities does not discriminate pursuant to the federal Fair Housing Act.*

C O N F I D E N T I A L

# APPLICATION FOR RESIDENCY



**COVENANT**  
Retirement Communities

CRC does not discriminate pursuant to the federal Fair Housing Act.

Name     
*Last First Middle*

Unit Size Desired  Studio  1 Bedroom  2 Bedroom  Other

## A. PERSONAL INFORMATION

Address

City  State  Zip

Telephone  Cell Phone Number

Years at this Address  E-Mail

*If less than ten years at address shown above, please provide previous address below:*

Date of Birth  Age

Are you a U.S. citizen?  Yes  No

Indicate whether you are:  Single  Married  Divorced  Widowed

If married, name of spouse  Date Married

If widowed, indicate name of spouse, and date of death

Applicant's occupation or former occupation  Retired

Employed by (last or present employer)

Do you have a current driver's license?  Yes  No

If yes, please provide state and driver's license number

Have you been convicted of a crime, other than a traffic offense, in the past ten years?  Yes  No

## B. CHILDREN

1. Name  Age

Address

City  State  Zip  Telephone

E-Mail  Cell Phone

**B. CHILDREN** *(continued)*

2. Name  Age   
Address   
City  State  Zip  Telephone   
E-Mail  Cell Phone

3. Name  Age   
Address   
City  State  Zip  Telephone   
E-Mail  Cell Phone

*Use attached sheet of paper if more space is needed*

**C. CHURCH AFFILIATION (OPTIONAL)**

Name of Church  Denomination   
City  State

**D. INSURANCE: Please list your health insurance coverage information.**

Medicare ID number   
Medicare replacement *(company & ID number)*   
Prescription drug *(company & ID number)*   
Other insurance

**E. OTHER**

Are you a current smoker?  Yes  No      Do you have a pet?  Yes  No

**F. SIGNATURE**

I understand that this application for residency is true and correct and that upon approval and upon signing of a residency agreement the information provided will become part of the residency agreement with the community and that any misrepresentation or omission may cause the residency agreement to be voided at the option of Covenant Retirement Communities.

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date Signed*

A separate application is required for each applicant. The Applicant's Financial Report, using the form supplied by Covenant Retirement Communities following must accompany each application with a copy of a photo identification card such as driver license or state identification card.

**USE THIS CONTINUATION SHEET FOR ADDITIONAL CHILDREN**

4. Name  Age   
Address   
City  State  Zip  Telephone   
E-Mail  Cell Phone

5. Name  Age   
Address   
City  State  Zip  Telephone   
E-Mail  Cell Phone

6. Name  Age   
Address   
City  State  Zip  Telephone   
E-Mail  Cell Phone

7. Name  Age   
Address   
City  State  Zip  Telephone   
E-Mail  Cell Phone

8. Name  Age   
Address   
City  State  Zip  Telephone   
E-Mail  Cell Phone

APPLICANT'S FINANCIAL REPORT



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Name of Applicant (Applicant 1)  Date of Birth

Name of Co Applicant (Applicant 2)  Date of Birth

Relationship of Applicant 1 to Applicant 2

*Please complete this report as accurately as possible. Supply information as of the date you complete the report and use additional paper if needed.*

**PART I: ASSETS**

**Part I Section 1: Real Estate**

- **Description:** List address of property or other identifying characteristics.
- **Value:** Your share of the market value minus expected selling costs.
- **Mortgage/Loans:** Total outstanding mortgage and/or home equity loans against the real estate.
- **Surviving spouse %:** The amount of real estate that is designated to surviving spouse or co-applicant.
- **Note:** All assets assumed to be jointly owned with spouse or co applicant unless otherwise specified.

	Description	Value	Mortgage/Loans	Survivor %	Notes
Primary Residence		\$	\$	%	
Other real estate (non-rental)		\$	\$	%	
Other real estate (non-rental)		\$	\$	%	

Please state how the current value was determined, i.e. appraisal, etc:

Date of appraisal

**PART I: ASSETS****Part I Section 2: Savings and Investments**

- **Current Balance:** Record totals only for stocks and bonds rather than listing individually.
- **Income:** Provide the annual percentage rate (APR) based on historical averages, or record the monthly interest and dividend income.
- **Is the income taxable?** Circle Yes or No.
- **Survivor %:** The amount bequeathed to surviving spouse / co applicant.
- **Note:** All assets assumed to be jointly owned with spouse or co applicant unless otherwise specified.

	<b>Current Balance</b>	<b>Income (\$ or %)</b>	<b>Taxable? (circle one)</b>	<b>Survivor %</b>	<b>Notes</b>
Cash / Checking Accounts	\$		Y / N	%	
Savings / CDs	\$		Y / N	%	
Money Market Accounts	\$		Y / N	%	
Stocks / Mutual Funds	\$		Y / N	%	
Bonds / Bond Funds	\$		Y / N	%	
Other	\$		Y / N	%	
Other	\$		Y / N	%	

**Part I Section 3: Life Insurance**

- Record only policies with a current asset value or listing spouse / co-applicant as beneficiary.
- **Owner:** Applicant 1 / Applicant 2 as defined on Page 1.
- **Type of policy:** Indicate type of policy such as term or whole life.
- **Cash Value:** Amount currently available for withdrawal from policy.
- **Death Benefit:** The greater of the face amount or cash value minus any policy loans.
- **Survivor %:** The amount bequeathed to the surviving spouse / co-applicant.

<b>Owner (circle one)</b>	<b>Type of Policy</b>	<b>Cash Value</b>	<b>Death Benefit</b>	<b>Survivor %</b>
App 1 / App 2		\$	\$	%
App 1 / App 2		\$	\$	%
App 1 / App 2		\$	\$	%

**Part I Section 4: Other Assets**

- **Description:** Describe asset.
- **Value:** Market value of the asset.
- (If real estate) **Mortgage/Loans:** Total outstanding mortgage and/or home equity loans against the real estate.
- **Income:** Provide the annual percentage rate (APR) based on historical averages, or record the monthly interest and dividend income.
- Is the asset expected to appreciate? Circle Yes or No.
- Is the income taxable? Circle Yes or No.
- **Surviving spouse %:** The amount of real estate that is designated to surviving spouse or co-applicant.
- **Note:** All assets assumed to be jointly owned with spouse or co applicant unless otherwise specified.

Description	Value	Mortgage/ Loans	Income (\$ or %)	Appreciate	Taxable	Survivor %	Notes
	\$	\$		Y / N	Y / N	%	
	\$	\$		Y / N	Y / N	%	
	\$	\$		Y / N	Y / N	%	
	\$	\$		Y / N	Y / N	%	
	\$	\$		Y / N	Y / N	%	
	\$	\$		Y / N	Y / N	%	

**PART II: LIABILITIES**

- **Applicant:** Applicant 1 / Applicant 2 as defined on Page 1.
- **Description:** Describe liability.
- **Balance:** List full amount borrowed or due of liability.
- **Notes:** Provide other information as necessary and if liability included in net value on any other schedule.

Applicant (circle one or both responsible)	Description	Balance	Notes
App 1 / App 2	Credit Card Balances	\$	
App 1 / App 2	Vehicle Loans	\$	
App 1 / App 2	Notes Payable	\$	
App 1 / App 2	Other	\$	
App 1 / App 2	Other	\$	
App 1 / App 2	Other	\$	
App 1 / App 2	Other	\$	

## PART III: MONTHLY INCOME

### Part III Section 1: Social Security

- **Monthly Social Security App 1 / 2:** Enter amount of monthly social security income received or expected to be received.
- **Date:** Insert date Social Security income will begin in the future if it has not begun already.

Monthly Social Security App 1	Date	Monthly Social Security App 2	Date

### Part III Section 2: Pensions and Annuities

- **Owner:** Applicant 1 / Applicant 2 as defined on Page 1.
- **Description:** Define as pension or annuity.
- **Monthly Income:** Provide monthly income amount.
- **Duration:** Enter a start and end date or start date and "lifetime."
- **Adjust:** Does the income adjust for inflation? Circle Yes or No.
- **Survivor %:** Percentage bequeathed to surviving spouse / co-applicant.

Owner (circle one)	Description	Monthly Income	Duration	Adjust	Survivor %
App 1 / App 2		\$		Y / N	%
App 1 / App 2		\$		Y / N	%
App 1 / App 2		\$		Y / N	%
App 1 / App 2		\$		Y / N	%

### Part III Section 3: IRAs, Roth IRAs, 401(k)

- **Owner:** Applicant 1 / Applicant 2 as defined on Page 1
- **Description:** Describe IRA / 401(k)
- Balance in accounts.
- **Monthly Income:** Provide monthly income amount.
- **Duration:** Enter a start and end date or start date and "lifetime."
- **Adjust:** Does the income adjust for inflation? Circle Yes or No.
- **Survivor %:** Percentage bequeathed to surviving spouse / co-applicant.

Owner (circle one)	Description	Balance	Monthly Income	Duration	Adjust	Survivor %
App 1 / App 2		\$	\$		Y / N	%
App 1 / App 2		\$	\$		Y / N	%
App 1 / App 2		\$	\$		Y / N	%
App 1 / App 2		\$	\$		Y / N	%



**Part III Section 4: Other Income**

- **Owner:** Applicant 1 / Applicant 2 as defined on Page 1.
- **Description:** Describe the source of income.
- **Monthly Income:** Provide monthly income amount.
- **Duration:** Enter a start and end date or start date and "lifetime."
- **Adjust:** Does the income adjust for inflation? Circle Yes or No.
- **Survivor %:** Percentage bequeathed to surviving spouse / co-applicant.

Owner (circle one)	Description	Monthly Income	Duration	Adjust	Survivor %
App 1 / App 2		\$		Y / N	%
App 1 / App 2		\$		Y / N	%
App 1 / App 2		\$		Y / N	%
App 1 / App 2		\$		Y / N	%

**PART IV: LONG TERM CARE INSURANCE**

Do you have Long Term Care Insurance? YES  NO

If yes, please complete the following:

	Applicant 1	Applicant 2
Long Term Insurance Provider		
Benefit Period (Time limit on payments to you, generally 1 yr, 2yr, 5yr or lifetime)		
Elimination Period (Waiting period before payments start, generally 30, 60 or 90 days)		
Daily benefit in Assisted Living (current dollars)	\$	\$
Daily benefit in Nursing Care (current dollars)	\$	\$
Daily benefit for Home Care (current dollars)	\$	\$
Does the daily benefit increase with Inflation? (Circle Yes or No)	Y / N	Y / N
Annual Premium	\$	\$
Assumed inflation rate on annual premiums	%	%

**PART V: MONTHLY EXPENSES**

Estimate your monthly expenses living in the community. Do not include monthly maintenance fee.

	<b>Applicant 1</b>	<b>Applicant 2</b>
Insurance Premiums ( <i>Excluding long term care insurance reported above</i> )		
Prescription and other Medical Costs		
Groceries and Meals ( <i>amount not included in monthly fee</i> )		
Travel and Entertainment		
Personal Items and Clothing		
Automobile Expenses ( <i>insurance, gas, maintenance</i> )		
Charitable Contributions		
Incidentals ( <i>i.e. telephone, gifts, beauty, barber, etc</i> )		
Other		
Other		
Other		
<b>Total</b>		

**SIGNATURE**

I understand that this financial report is true and correct and that upon approval and upon signing of a residency agreement the information provided will become part of the residency agreement with the community and that any misrepresentation or omission may cause the residency agreement to be voided at the option of Covenant Retirement Communities. I (we) agree to make no changes in my (our) financial status that will prevent me (us) from providing my (our) own financial needs while a resident.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date Signed

**FOR INTERNAL PROCESSING ONLY, DO NOT COMPLETE.**

Contract Type

Unit Type at Entry

Expected Date of Entry

Service Level at Entry

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**PHYSICIAN'S ASSESSMENT (CONFIDENTIAL)**

*Note to Physician: The person whose name appears below is an applicant for admission to a Covenant Retirement Community. A current health report is required as part of the application process.*

Purpose of Assessment:       Pre-Admission       Renewal      Date of Examination: \_\_\_\_\_

**➤ Applicant Demographics**

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex:  M  F      Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address (if known): \_\_\_\_\_

**➤ Diagnosis**

Primary: \_\_\_\_\_

a. Can applicant manage own treatment/medication/equipment?     YES     NO

b. If not, what type of medical supervision is needed?

\_\_\_\_\_

\_\_\_\_\_

Secondary: \_\_\_\_\_

a. Can applicant manage own treatment/medication/equipment?     YES     NO

b. If not, what type of medical supervision is needed?

\_\_\_\_\_

\_\_\_\_\_

Other:       PPD     Mantoux      Date Received:      Results:     None/Inactive     Active/Quiescent

If contraindicated, state reason

**➤ Physical Health**

Weight:	Height:	Additional Notes:
Pulse:	Blood Pressure:	

Functional Abilities:	Good	Fair	Poor	Additional Information
Hearing (with or without device)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision (with or without corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking/Mobility (with or without device)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Activities of Daily Living	Self	Assistance Req.	Additional Information
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting/Toilet Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	
Transferring (bed to chair/chair to toilet)	<input type="checkbox"/>	<input type="checkbox"/>	
Oral Hygiene/Denture Care	<input type="checkbox"/>	<input type="checkbox"/>	
Eating at meal time	<input type="checkbox"/>	<input type="checkbox"/>	
Driving (day,night, or both)	<input type="checkbox"/>	<input type="checkbox"/>	

**Cognitive Status:**     Alert     Confused     Short-term memory loss     Long-term memory loss

If confused, or applicant has memory loss, please explain:

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Evidence of Dementia?     YES     NO

If yes, please explain:

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History of Mental Illness / Mental Health Problems?     YES     NO

Diagnosis, if known:

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**MEDICATION:** Specify medication(s) prescribed, dosage, frequency and instructions given for applicant.

Prescribed Medication	Dosage	Frequency by time	Instructions
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Supplements/Over-the Counter	Dosage	Frequency by time	Instructions
1.			
2.			
3.			
4.			
5.			

Alternative Treatments (Holistic/Natural/Homeopathic/Massage, etc...)	Frequency
1.	
2.	
3.	

➔ **MEDICAL HISTORY:** Does the applicant's medical history include any of the following? If yes, please provide details. Use additional sheet if necessary.

	YES	NO		YES	NO
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
ASHD Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hematological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatic Pathology	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Cardio Vascular Accident	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Vascular Accident	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Developmentally Disabled	<input type="checkbox"/>	<input type="checkbox"/>	Renal Pathology	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	TBC	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Other		

Other Details: \_\_\_\_\_

Hospitalization(s) in the last 5 years:

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

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

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

Surgeries:

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

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

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

Special Treatments and Procedures, not listed above (Narrative)

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

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

Allergies:  NO  YES, please explain: \_\_\_\_\_

Any recent falls?  NO  YES, please explain: \_\_\_\_\_

**Routine Orders:**

Routine Lab Work  NO  YES Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Podiatry Services  NO  YES Frequency: \_\_\_\_\_

Annual Flu Vaccine  NO  YES Date last received: \_\_\_\_\_

Other: \_\_\_\_\_

Special Diet Requirements:  Regular  No added salt  Diabetic  Other: \_\_\_\_\_

Any additional information from your records which you consider an important part of the applicant's medical history will be helpful. Please use additional sheet if necessary.

**IMPORTANT:**

In your professional opinion, is the applicant mentally and physically capable of leaving a building without assistance in an emergency?  YES  NO, please explain:

Does applicant need outside care-giving support, or relies on another person for assistance?  NO  YES, please explain:

Would you recommend the applicant for a campus-sponsored fitness program?  YES  NO

Are there any restrictions to consider?  NO  YES, please explain:

**PHYSICIAN INFORMATION**

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address (if known): \_\_\_\_\_

Signature of Physician

Date		

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:**

I hereby authorize the release of medical information contained in the report examination of:

Name of Applicant (Print)
Signature (Applicant or Responsible Party)

Self or Relationship to Applicant		
Date		