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 _____

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

APPLICANT'S **FINANCIAL REPORT**

COVENANT
Retirement Communities

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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.

	Current Balance	Income ($ or %)	Taxable? (circle one)	Survivor %	Notes
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.

Owner (circle one)	Type of Policy	Cash Value	Death Benefit	Survivor %
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.

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

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 _____

COVENANT VILLAGE OF CROMWELL
A Covenant Retirement Community

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

Covenant Village of Cromwell
Attn: Wellness Office
52 Missionary Road
Cromwell, CT 06416-2143
Phone: 860.635.2690 or 860.635.5511
Fax: 860.632.2407 or 860.635.1497

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)	❑	❑	❑	
Vision (with or without corrective lenses)	❑	❑	❑	
Speech	❑	❑	❑	
Walking/Mobility (with or without device)	❑	❑	❑	

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

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

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

Evidence of Dementia? ❑ YES ❑ NO

If yes, please explain:

History of Mental Illness / Mental Health Problems? ❑ YES ❑ NO

Diagnosis, if known:

➲ **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	❑	❑	Glaucoma	❑	❑
ASHD Disorder	❑	❑	Hematological Disorders	❑	❑
Asthma	❑	❑	Hepatic Pathology	❑	❑
Cancer	❑	❑	Hepatitis B	❑	❑
Cardio Vascular Accident	❑	❑	High Cholesterol	❑	❑
Cataracts	❑	❑	Hypertension	❑	❑
Cerebral Arteriosclerosis	❑	❑	Incontinence	❑	❑
Cerebral Vascular Accident	❑	❑	Neurological Disease	❑	❑
Chronic Obstructive Lung Disease	❑	❑	Osteoporosis	❑	❑
Colitis	❑	❑	Pancreatitis	❑	❑
Coronary Artery Disease	❑	❑	Pulmonary Disease	❑	❑
Depression	❑	❑	Parkinson's Disease	❑	❑
Developmentally Disabled	❑	❑	Renal Pathology	❑	❑
Diabetes	❑	❑	Stroke	❑	❑
Diverticulosis	❑	❑	TBC	❑	❑
Epilepsy/Seizures	❑	❑	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)	Self or Relationship to Applicant		
Signature (Applicant or Responsible Party)	Date		