BROOKE GROVE RETIREMENT VILLAGE

APPLICATION FOR:

_____

Name

Cottage Preferences:

(You may check more than one.)

- ❒ The Isaac Briggs on Hickory Knoll
- ❒ The Marston on Hickory Knoll
- ❒ The Brooke on Hickory Knoll
- ❒ The Briggs Creek on Poplar View
- ❒ The Marston Manor on Poplar View
- ❒ The Brooke Meadow on Poplar View

Preferred Entrance Fee:

❒ 72-month declining option ❒ 50% option ❒ 90% option

One or more of these options may be prioritized. Details are included on individual cottage flyers.

Other Residential Living and Care Services:

❒ Assisted Living ❒ Rehabilitation ❒ Skilled Nursing ❒ Respite

Please tell us how you heard about Brooke Grove.

_____

Please include copies of the following:

- The front and back of the Medicare card and all other insurance cards (including pharmacy plan cards)
- Copies of any Power of Attorney documents
- Copies of any Guardianship documents
- Copies of Living Will and Advance Directives

The application and all documents may be faxed to us at 301-924-1591 or emailed to your retirement counselor. If you prefer, we can copy them for you in the sales office.

Sales Office Phone: 301-260-2320
18121 Slade School Road, Sandy Spring, MD 20860

BROOKE GROVE
RETIREMENT VILLAGE

Application for Residency or Admission

GENERAL

Prospect Name: _____
First Middle Last (Maiden Name if applicable)

Current Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Gender: ❒ Male ❒ Female **Marital Status:** ❒ Never Married ❒ Widowed ❒ Divorced ❒ Married

***Religion:** _____ ***Race:** _____ ***Ethnicity:** _____

***Highest Level of Education:** _____ **Lifetime Occupation:** _____

Primary Language: _____ **Language 2:** _____

Date of Birth: _____ **U.S. Citizen:** ❒ Yes ❒ No **Veteran:** ❒ Yes ❒ No

Birth City: _____ **Birth State:** _____

Prospect is now at: ❒ Home ❒ Hospital ❒ Other _____

Has the prospect been admitted to a hospital or other nursing or rehabilitation center within the last year? ❒ Yes ❒ No

If yes, where: _____ Dates: _____

Has the prospect ever been enrolled in the following? ❒ Hospice ❒ Home Care

PHYSICIAN

Primary Care Physician: _____

Phone: _____ **Fax:** _____

Other Physicians: _____

Preferred physician, if community physician does not attend at Brooke Grove: _____

Date of last influenza vaccine: _____ **Pneumonia vaccine:** _____ **Shingles vaccine:** _____

INSURANCE

Social Security #: _____ **Medicaid #:** _____

Medicare #: _____ ❒ A ❒ B **Is Medicare primary?** ❒ Yes ❒ No

Medicare Advantage Plan or Other Insurance: _____

HMO? ❒ Yes ❒ No **Policy #:** _____

Address: _____

Secondary Insurance: _____ **Policy #:** _____

Pharmacy or Medicare D Plan: _____ **Policy #:** _____

Does prospect have Long-term Care Insurance? ❒ Yes ❒ No

_____
Provider

**Optional information requested by Medicare*

FINANCIAL CONTACT

Financial Contact Information (this is only for where bills should be sent)**:**

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Fax: _____ Preferred method of contact: _____

Check all that apply: ❒ Financial POA ❒ Healthcare POA ❒ Guardian ❒ Emergency Contact

If prospect is not able to sign admission paperwork, who will do so? _____

EMERGENCY CONTACTS

Primary Emergency Contacts (in order of priority)**:**

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Check all that apply: ❒ Financial POA ❒ Healthcare POA ❒ Guardian ❒ Emergency Contact

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Check all that apply: ❒ Financial POA ❒ Healthcare POA ❒ Guardian ❒ Emergency Contact

Does prospect have an Advanced Directive? ❒ Yes ❒ No (*Please provide a copy of these documents.*)

Please list anyone else with whom we have permission to share medical information:

_____

Please provide copies of all Power of Attorney, Advance Directives or Guardianship documents.

I hereby certify that to the best of my knowledge and belief, the above stated information is correct and complete. I understand that Brooke Grove Retirement Village may, at its sole discretion, void the facility agreement if any information is falsely represented.

I understand that I may not have been asked to provide complete financial information at this time. If Brooke Grove Retirement Village should determine that additional information is required, I agree to provide complete and accurate financial information without delay.

I authorize Brooke Grove Retirement Village to disclose information contained in this form or the facility agreement to facilitate application and/or coordinate benefits from Medicare, Medicaid and other payers.

Prospect or Responsible Party Signature: _____ *Date:* _____

Retirement Counselor or Admissions Coordinator Signature: _____ *Date:* _____

Financial Application for: _____

Please supply complete information pertaining to the applicant's resources available for payment of fees while at Brooke Grove Retirement Village. This list should include any jointly held assets.

FINANCIAL

Monthly Income	Applicant	Spouse
Social Security:	$_____	$_____
Civil Service Retirement:	$_____	$_____
V.A. Pension*:	$_____	$_____
Military Retirement*:	$_____	$_____
Railroad Retirement*:	$_____	$_____
Rental Income:	$_____	$_____
Other: _____ (Specify)	$_____	$_____

**Does the pension income include survivor or death benefits?* ❒ Yes ❒ No *If yes, please explain:*

_____

Long-term Care Insurance: _____ Phone: _____

Policy #: _____ Daily Amount: $_____ Total Value: $_____ Elimination Period: _____

Cash Assets in Banks, Credit Unions, Saving and Financial Institutions:

Institution Name: _____ Location: _____

Type of Account: _____ Balance in Account: $_____

Institution Name: _____ Location: _____

Type of Account: _____ Balance in Account: $_____

Institution Name: _____ Location: _____

Type of Account: _____ Balance in Account: $_____

ASSETS

Other Assets/Investments (stocks, bonds, IRAs):

Company Name: _____ Approx. Value: $_____ Monthly Income: $_____

Company Name: _____ Approx. Value: $_____ Monthly Income: $_____

Company Name: _____ Approx. Value: $_____ Monthly Income: $_____

Company Name: _____ Approx. Value: $_____ Monthly Income: $_____

Please list any additional assets on a separate sheet of paper.

FINANCIAL

Does the prospect own their own home? ❒ Yes ❒ No Approximate Value: $_____

Street Address: _____

County: _____ City: _____ State: _____ Zip Code: _____

Is the property jointly owned? ❒ Yes ❒ No Name of Co-owner(s): _____

Are there any liens or encumbrances on this property? ❒ Yes ❒ No

Mortgage Balance: $ _____ Reverse Mortgage or Line of Credit: $_____

Does the prospect own any additional property? ❒ Yes ❒ No Value: $_____

Street Address: _____

County: _____ City: _____ State: _____ Zip Code: _____

Is the property jointly owned? ❒ Yes ❒ No Name of Co-owner(s): _____

Are there any liens or encumbrances on this property? ❒ Yes ❒ No

Mortgage Balance: $ _____ Reverse Mortgage or Line of Credit: $_____

Any other additional property? ❒ Yes ❒ No *If yes, please list on a separate sheet of paper.*

Has the prospect sold a home or transferred any assets to anyone in the last 5 years? ❒ Yes ❒ No

If so, please provide details: _____

Does the prospect own any life insurance policies? ❒ Yes ❒ No Cash Value: $_____

VETERANS BENEFITS

Have you or your spouse served in the military: ❒ Yes ❒ No

If so, who? _____

Dates of service: _____ Was the service during wartime? ❒ Yes ❒ No

Note: Veterans benefits may be available to pay for a portion of your care.

MEDICAID

Medicaid/Title XIX (19):

Has the prospect applied, or will they soon be applying, for Medicaid/Medical Assistance? ❒ Yes ❒ No

Medicaid #: _____ Date Applied: _____

County: _____ State: _____

I hereby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete.

I understand that Brooke Grove Retirement Village may, at its sole discretion, void the facility agreement if monies represented herein to pay Brooke Grove Retirement Village for the resident's care at one of Brooke Grove Retirement Village's facilities are used for purposes other than to provide for the resident's needs.

I authorize Brooke Grove Retirement Village to obtain such credit reports as it determines necessary to establish and monitor the resident's financial eligibility for care at one of Brooke Grove Retirement Village's facilities.

Applicant or Responsible Party Signature: _____ *Date:* _____

Retirement Counselor or
Admissions Coordinator Signature: _____ *Date:* _____