Navigation
AT HOME

APPLICATION FOR MEMBERSHIP

Applicant: _____

(Please print full name)

Application Process

Navigation at Home accepts applications from persons age 62 years or older, or in the case of a household application, one of the two persons must be 62 years or older. Eligible applicants will be considered without regard to their sex, race, religion, color, national origin, political beliefs, or ancestry.

Navigation at Home requires prospective members to meet predetermined age, health and financial requirements, prior to acceptance into the program.

Documents/Documentation required for acceptance:

- Application processing fee of $250.00 for one person, additional $50 for second member of the household*.
- Personal Health History
- Release of Medical Information Form
- Financial Records (Bank statements, documentation of Trust, whether revocable or irrevocable, brokerage statements, detailing shares of stock owned, if not managed by a broker, etc.).
- Copy of Medicare Card and Supplementary Insurance Card (back and front).

***non-refundable fee**

Acceptance Process

- All financial documents are reviewed by the Finance Department to determine financial viability.
- Medical/Health records are assessed by the Care Coordinator and/or Medical Director based on objective medical underwriting criteria.
- All prospective members will be notified of the decision by the Membership Committee and a personal meeting will be held to discuss and review the terms and conditions of acceptance as outlined the Membership Agreement

Month, Day, Year

Membership Plans					
Please check one:	○	○	○	○	○
Services	**All Inclusive**	**All Inclusive Plus**	**Enhanced**	**Classic**	**Bridge**
Care Coordination, Transportation, Meal Delivery Emergency Response System	100%	100%	100%	100%	100%
Home Health Aide, Companion/Homemaker, Adult Day Care	100%	100%	85%	50%	65%
Assisted Living / Nursing Home Care	100%	100%	70%	50%	0%

Confidential Profile

Title: ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. ☐ Miss ☐ Rev.

Full Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____ Email: _____

Home Phone: _____ Other Phone: _____

Height: _____ Weight: _____ Social Security: _____

Medicare Number #: _____ ☐ Part A ☐ Part B

Please provide a copy of your card-front and back

Supplemental Medicare Insurance Company: _____

Please provide a copy of your card-front and back

Policy #: _____ Group #: _____

Do you have prescription coverage? ☐ Yes ☐ No

_____

Month, Day, Year

Health Information

Have you had a complete physical examination in the past 12 months? ☐ Yes ☐ No

Do you currently use tobacco, or have you used in the past 2 years? ☐ Yes ☐ No

List any known food and/or drug allergies (use an additional sheet if necessary):

_____

_____

Do you currently receive assistance in your home? ☐ Yes ☐ No

If **yes**, how many hours per week and what type of assistance do you receive:

_____

Do you drive? ☐ Yes ☐ No

If **no**, please give a brief explanation why:

_____

Do you use handicap parking? ☐ Yes ☐ No

If **yes**, please give a brief explanation why:

_____

Do you regularly engage in weekly physical activity? ☐ Yes ☐ No

If **yes**, give a brief explanation of type of activity. If **no**, please explain why not:

_____

_____

List the name and phone number of all current physicians and specialists (use an additional sheet if necessary):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

List the medications you currently take, including over-the-counter and herbal preparations (use an additional sheet if necessary):

_____

_____

_____

Month, Day, Year

List any additional medical conditions, including upcoming surgeries.

_____

_____

_____

Do you have or have you had any of the following?

☐ Alcoholism or Drug Addiction ☐ Rheumatoid Arthritis, Gout ☐ Black Out Spells ☐ Bladder/Bowel Incontinence ☐ Cancer or Leukemia (Date of last treatment_____) ☐ Dementia or Alzheimer's ☐ Major Depression/Anxiety ☐ Diabetes Requiring Insulin Injections ☐ Dizziness ☐ Eye Disease or Blindness ☐ Fractures ☐ Heart Disease, Angina Pectoris, Coronary Artery Disease, Congestive Heart Failure, Peripheral Vascular Disease ☐ Heart Attack	☐ Hypertension ☐ Kidney Disease, Including End Stage Renal Disease (ESRD) ☐ Liver Disease, Hepatitis B or C, Cirrhosis ☐ Mental Disease/Disorder Bipolar Disorder, Schizophrenia, Psychosis ☐ Lung Disease, Asthma, Emphysema ☐ Organ Transplant, or Advised to Have One ☐ Osteoporosis, Connective Tissue Disorder, Severe Bone or Joint Disease ☐ Pacemaker, Abnormal Heart Rhythm ☐ Parkinson, ALS, MS, Neuropathy ☐ Seizures ☐ Stroke Or TIA ☐ TB

If you answered "yes" to any item, please use the space below to provide further details, including dates, diagnosis, and treatments:

_____

_____

_____

_____

_____

_____

_____

Month, Day, Year

Financial Disclosure – Confidential

Each Applicant for membership into Navigation at Home is required to give a disclosure of financial resources and obligations. Salemtowne respects the privacy of every Applicant and does not wish to intrude into your personal circumstances other than to verify that funds are adequate to cover life expectancy in the program. Verification of the information on this form is required. All statements must show owner name and the date on the document. Additional information may be requested. Applicants in the same household with shared financial responsibility may submit one combined Financial Disclosure form.

ASSETS

Please provide a copy of your most current statement for accounts listed below. If you have a trust, please provide a copy of the trust document.

	BANK/BROKERAGE FIRM	CURRENT VALUE
Cash (savings or checking)		
Cash (savings or checking)		
CDs		
Investment Account		
Investment Account		
Investment Account		
Trust		
Other		
Other		
Other		
Total Assets		**$**

LIABILITIES

Please provide copies of all liabilities (such as balances on mortgages, loans, credit cards, guarantees). You do not need to list normal routine monthly expenses such as gas, water, electric amounts.

LIABILITY	OUTSTANDING BALANCE	INTEREST RATE%

Month, Day, Year

INCOME

Please provide bank statements that show income deposits.

	APPLICANT 1	APPLICANT 2
Social Security		

Pension Income		
Does income adjust for inflation?	□ Yes □ No	□ Yes □ No
Rate:		

Annuity Income		
Is this a lifetime annuity?	□ Yes □ No	□ Yes □ No
If no, what are the terms?		
Does income adjust for inflation?	□ Yes □ No	□ Yes □ No
Rate:		
Date of first payment:		

Rental Income		
Other Income		
Other Income		

Total Monthly Income		

LONG TERM CARE INSURANCE

Do you have Long Term Care Insurance? ☐ Yes ☐ No

If yes, please complete the information below.

Company:	_____	Date Purchased:	_____	Premium	$_____
Maximum Benefit:	$_____ Or Yrs_____	Inflation Rider:	_____%	Elimination Period:	_____
In Home Care:	$_____ ☐ Daily ☐ Monthly	Assisted Living:	$_____ ☐ Daily ☐ Monthly	Skilled Nursing:	$_____ ☐ Daily ☐ Monthly

Month, Day, Year

Application Signature

The information provided in the Confidential Financial Disclosure is true and may be relied upon with confidence by Navigation at Home Management in my (our) membership application process. I (we) understand that additional information may be requested from time to time. I (we) will not transfer or reduce resources necessary to carry out the financial commitment to Navigation at Home.

Navigation at Home respects your right to privacy and safeguards the confidential personal information you provide us in this Application. Except as set forth below, Navigation at Home will not disclose any confidential personal information it gathers from you. We may release such personal information to affiliates, agents, and third parties to comply with valid legal requirements such as a law, regulation, or court order; or in special cases, such as for your own health, benefit or welfare. We require all affiliates, agents, and third parties to treat your information confidentially. In the event that we are legally compelled to disclose such personal information to a third party, we will notify you unless doing so would violate the law or court order. Under no circumstances do we sell confidential personal information to third parties for marketing purposes.

I hereby declare that all statements made herein are true and complete according to my best knowledge and belief. In witness whereof, I have set my hand to this application

this _____ day of _____, 20 _____.

_____

Applicant Signature (or POA)

Navigation
AT HOME

PROTECTION | COORDINATION | CARE

1000 Salemtowne Drive | Winston-Salem, NC 27106

336.714.6848

Month, Day, Year