Application for Membership

Applicant: _____

(Please print full name)

Application Process

Navigation by Salemtowne 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 by Salemtowne 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 (must include statement indicating prospective member is in good health and independent).
- 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.

Membership Plans				
Please check one:	○	○	○	○
Services	**All Inclusive**	**Security**	**Co-Pay**	**Beacon**
Care Coordination, Transportation, Meal Delivery (as limited in Agreement), Emergency Response System, Home Inspection	100%	100%	100%	100%
Home Health Aide, Companion/Homemaker, Live in Companion Adult Day Care	100%	85%	50%	65%
Assisted Living / Nursing Home Care	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

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):

_____

_____

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):

_____

_____

_____

_____

List any additional medical conditions, including upcoming surgeries.

_____

_____

_____

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:

_____

_____

Health Information

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

☐ **Yes** ☐ **No** Alcoholism Or Drug Addiction

☐ **Yes** ☐ **No** Rheumatoid Arthritis, Gout

☐ **Yes** ☐ **No** Black Out Spells

☐ **Yes** ☐ **No** Bladder/Bowel Incontinence

☐ **Yes** ☐ **No** Cancer or Leukemia (Date of last treatment_____)

☐ **Yes** ☐ **No** Dementia Or Alzheimer's

☐ **Yes** ☐ **No** Major Depression/Anxiety

☐ **Yes** ☐ **No** Diabetes Requiring Insulin Injections

☐ **Yes** ☐ **No** Dizziness

☐ **Yes** ☐ **No** Eye Disease Or Blindness

☐ **Yes** ☐ **No** Fractures

☐ **Yes** ☐ **No** Heart Disease, Angina Pectoris, Coronary Artery Disease, Congestive Heart Failure, Peripheral Vascular Disease

☐ **Yes** ☐ **No** Heart Attack

☐ **Yes** ☐ **No** Hypertension

☐ **Yes** ☐ **No** Kidney Disease, Including End Stage Renal Disease (ESRD)

☐ **Yes** ☐ **No** Liver Disease, Hepatitis B or C, Cirrhosis

☐ **Yes** ☐ **No** Mental Disease/Disorder Bipolar Disorder, Schizophrenia, Psychosis

☐ **Yes** ☐ **No** Lung Disease, Asthma, Emphysema

☐ **Yes** ☐ **No** Organ Transplant, or Advised To Have One

☐ **Yes** ☐ **No** Osteoporosis, Connective Tissue Disorder, Severe Bone or Joint Disease

☐ **Yes** ☐ **No** Pacemaker , Abnormal Heart Rhythm

☐ **Yes** ☐ **No** Parkinson, ALS, MS, Neuropathy

☐ **Yes** ☐ **No** Seizures

☐ **Yes** ☐ **No** Stroke Or TIA

☐ **Yes** ☐ **No** TB

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

_____

_____

_____

_____

Financial Disclosure - Confidential

***Please provide most recent statement with date, bank name, account number(s), and your name visible. For stocks, please provide the number of shares.**

Assets:	**Balance**	**Annual Income**
Investment Account*_____	$ _____	$ _____
Investment Account*_____	$ _____	$ _____
Investment Account*_____	$ _____	$ _____
Certificates of Deposit*	$ _____	$ _____
Cash* (Checking, Savings, or Money Market	$ _____	$ _____
Annuity _____	$ _____	$ _____
Primary Real Estate (Tax Value or recent appraisal)	$ _____	$ _____
Secondary Real Estate (Tax Value or recent appraisal)	$ _____	$ _____
Other _____	$ _____	$ _____
Other _____	$ _____	$ _____
Total Assets:	**$ _____**	**$ _____**

Income:	**Monthly Income**	**To applicant (1) if applicant (2) predeceases**	**To applicant (2) if applicant (1) predeceases**
Social Security (1st applicant)	$ _____	$ _____	$ _____
Social Security (2nd applicant)	$ _____	$ _____	$ _____
Pension _____	$ _____	$ _____	$ _____
Pension _____	$ _____	$ _____	$ _____
Other _____	$ _____	$ _____	$ _____
Other _____	$ _____	$ _____	$ _____
Total Income:	**$ _____**		

Expenses/Debts:	**Monthly Expense**	**Balance**	**Interest Rate**
Mortgage Payment	$_____	$_____	_____%
Credit Cards	$_____	$_____	_____%
Auto Payment	$_____	$_____	_____%
Home Utilities	$_____		
Totals:	**$ _____**	**$ _____**	

Long Term Care Insurance

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

If yes, please complete the information below. If no, please disregard.

Company: _____

Policy Number: _____

Date Purchased: _____

Monthly Premium: $_____

Maximum Benefit: $_____ ☐ Lifetime ☐ Annual

Benefit Period: _____

Inflation % increase _____%

Benefit % increase per year: _____%

In Home Care per day: $_____

Assisted Living per day: $_____

Skilled Nursing per day: $ _____

Elimination Period: _____ ☐ Calendar Days ☐ Days of Care

Application Signature

The information provided in the Confidential Financial Disclosure is true and may be relied upon with confidence by Navigation by Salemtowne 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 by Salemtowne.

Navigation by Salemtowne respects your right to privacy and safeguards the confidential personal information you provide us in this Application. Except as set forth below, Navigation by Salemtowne 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 by Salemtowne

1000 Salemtowne Drive

Winston-Salem, NC 27106

(336) 714-6848

www.navigationbysalemtowne.org