☐ Date_____
☐ APP Fee in
☐ Copy of Cards
☐ Copy FPOA/ MPOA
☐ Copy LW/HCD/POLST
☐ Financials
☐ Copies (3) ☐ FD
☐ Fax Medical
☐ Records Rec'd.
☐ Assessment date_____
☐ Move-in date_____
☐ Name Plate ordered:
☐ Picture of _____
☐ Blue_____

☐ DU
☐BV
☐ GA
☐ TJ
☐ AL
☐ MC
☐ SN
☐_____

FRANKE TOBEY JONES

Enjoy your age

Application for Residency
Franke Tobey Jones
Retirement Estates
5340 N. Bristol St.
Tacoma, WA 98407
(253) 752-6621 fax (253) 756-1862

Franke Tobey Jones is a Not for Profit CCRC 501 ©3 for persons 62 years or older that meet the financial and health requirements. An application fee of $750 per person must accompany this completed application, except for Skilled Nursing. This application fee is a one-time charge that does not need to be paid again for any subsequent applications to other facilities or services at FTJ. The application fee is non-refundable, except when either the prospective resident withdraws the application before the assessment is completed, or FTJ determines in the assessment that it does not provide the type of services appropriate to meet the prospective resident's needs. Refunds for this fee must be requested in writing, addressed to the Director of Resident Accommodations.

An incomplete application may delay your admission.

Name _____
(First) (Middle) (Last) (Date)

Address_____
(Street) (City) (State) (Zip)

Home phone (_____) _____ e-mail _____

Gender: ❍ Female ❍ Male Birth date _____ Age _____

Place of Birth _____ Wedding Anniversary date, if applicable _____

Marital Status: ❍ Married ❍ Never Married ❍ Separated ❍ Divorced ❍ Widowed

Race/Ethnicity: ❍ America Indian/Alaskan Native ❍ Asian Pac. Islander ❍ African American, not of Hispanic origin
❍ Hispanic ❍ White, not of Hispanic origin **Religion**: (if you want to disclose) _____

Social Security # _____ Medicare # _____

Medicare Supplemental Insurance Provider _____

Subscriber # _____ Group # _____ Phone # _____

Address _____

Please provide a copy of: (or bring in and we can make a copy for you at the front desk)

❍ Driver's License/ID ❍ Medicare Card ❍ POLST
❍ Insurance Card ❍ Social Security Card ❍ Medical & Financial Power of Attorney

Was the fact that FTJ is a Continuing Care Community (We offer all levels of care) a big part of your decision to apply here? ❍ Yes ❍ No _____
How did you hear about us? _____
Do you know anyone who lives @ FTJ? _____
What did you like most about FTJ? _____

Personal Contacts

Primary Contact: _____
(Name) (E-mail)
Phone: _____
(Work) (Home) (Cell)
Address_____
(Street) (City) (State) (Zip)
Relationship _____ ❍Medical Power of Attorney ❍Financial Power of Attorney

---

Contact #2: _____
(Name) (E-mail)
Phone: _____
(Work) (Home) (Cell)
Address_____
(Street) (City) (State) (Zip)
Relationship _____ ❍Medical Power of Attorney ❍Financial Power of Attorney

---

Contact #3: _____
(Name) (E-mail)
Phone: _____
(Work) (Home) (Cell)
Address_____
(Street) (City) (State) (Zip)
Relationship _____ ❍Medical Power of Attorney ❍Financial Power of Attorney

---

Send billing information to: _____ ❍ Financial Power of Attorney
(Name)
Address _____
(Street) (City) (State) (Zip)
Phone: _____
(Work) (Home) (Cell)

Do you have a Long Term Care Policy? ❍ Yes ❍ No
Name of Long Term Care Provider: _____

Name of current facility (if at one) _____

Contact person at facility _____Phone # _____

Lifetime occupation _____
Education: (check highest level completed) ❍ 8th Grade/less ❍ 9-11th Grade ❍ High school
❍ Tech/Trade school ❍ Some college ❍ bachelor's degree ❍ Graduate degree
Interests/Hobbies:

- ☐ Arts/Crafts
- ☐ Cards/Board Games
- ☐ Church
- ☐ Cooking
- ☐ Cycling
- ☐ Dancing
- ☐ Exercising
- ☐ Food/Drink
- ☐ Knitting
- ☐ Gardening
- ☐ Golf
- ☐ Movies
- ☐ Music
- ☐ Painting
- ☐ Pets
- ☐ Photography
- ☐ Reading
- ☐ Stitchery/Quilting
- ☐ Sports watching
- ☐ Taking Classes/Sr. U
- ☐ Traveling
- ☐ Volunteering
- ☐ Walking/Hiking
- ☐ Wine/Beer Tasting
- ☐ Writing/Journaling
- ☐ Woodworking
- ☐ Other_____

Medical Contacts

Primary Physician_____
(Name) (Phone) (Fax)
Address_____
(Street) (City) (State) (Zip)

Alt. Physician _____
(Name) (Phone) (Fax)
Address_____
(Street) (City) (State) (Zip)

Dentist _____
(Name) (Phone) (Fax)
Address_____
(Street) (City) (State) (Zip)

Preferred Hospital _____ **Pharmacy** _____

Mortuary_____
(Name) (Phone)
Address_____
(Street) (City) (State) (Zip)

I understand that my application shall comprise the Personal Section, Legal Section, Financial Section and Medical Section and that a deposit must accompany the application in order that I may be put on the Waiting List.
I understand that failure to disclose the financial information will disqualify me from applying for subsidy in the future should I deplete my assets.

Within the last 20 years have you been convicted of a felony pertaining to Drugs, narcotics, theft, or assault of any kind? _____ yes _____ no

If yes, please explain (a conviction record alone will not necessarily bar you from residency)._____

_____ _____
Signature Date

CONFIDENTIAL FINANCIAL INFORMATION

Each applicant is asked to disclose personal financial information in this section. This information enables Franke Tobey Jones, as a continuing care retirement community, to assess the financial needs of the applicant over time, including the potential future need for charitable subsidy. The charitable subsidy program at Franke Tobey Jones is designed to provide assistance to residents who become unable to pay their fees, so that residency and care may continue within our community. A copy of the Charitable Subsidy policy is provided at admission. Please note Franke Tobey Jones does not have a contract with Medicare or Medicaid, so these resources should not be relied on to fund future care needs in our community.

The information provided in this disclosure is kept strictly confidential. We ask that you answer every question to make sure the information is complete. It is not necessary to provide exact amounts, account numbers or statements. You may elect to not disclose this financial information; however, you should be aware that in the application process for Charitable Subsidy priority is given to applicants who provided personal financial information to Franke Tobey Jones at admission.

Monthly Income

Income Source:	1st Person	2nd Person	Total
Social Security	$_____	$_____	$_____
Pensions	$_____	$_____	$_____
Investment Income	$_____	$_____	$_____
Rental Income	$_____	$_____	$_____
Other	$_____	$_____	$_____

Total Monthly Income **$_____**

Assets

Savings/Money Market Accounts:

Description		Current Balance
_____	_	$_____
_____		$_____
_____		$_____

Property: (Home, land, rental,etc.)

Description		Estimated Value
_____	_	$_____
_____		$_____
_____		$_____

Other Property or resources (life insurance cash value, etc:)

Description	Estimated Value
_____	$_____
_____	$_____

Assets (continued)

Investments: (Stocks/Bonds/IRA/Notes/Trusts)

Description		Current Value
_____	_	$_____
_____		$_____
_____		$_____
_____	_	$_____
_____		$_____
_____		$_____

Total Assets $_____

Mortgage Balances/Debts/Liabilities/Credit Card Balances

Description	Current Balance Due
_____	$_____
_____	$_____
_____	$_____

Total Liabilities $_____

Long Term Care Insurance

Do you have a Long Term Care Insurance policy that covers skilled nursing care or assisted living (not a supplemental policy)? Yes___ No___

If yes, how long does the policy cover? _____

If yes, what amount does the policy provide in coverage? _____

Please check the appropriate statement, and sign below:

___ The information in this application is true and accurate to the best of my knowledge.

___ I elect not to disclose this financial information with the awareness that in the application process for Charitable Subsidy priority is given to applicants who provided personal financial information to Franke Tobey Jones at admission.

_____
Applicant Name

_____ _____ ☐ **FD review_____**
Applicant Signature Date

Consent for Treatment

In case of emergency, I hereby authorize Franke Tobey Jones staff to summon help from the nearest or most readily available emergency or paramedical squad. I authorize following the squad's advice, including transfer to the nearest hospital, if recommended. I understand that I am responsible for costs incurred for such services. The Resident consents to nursing and other care as provided by the staff at Franke Tobey Jones (FTJ), including routine diagnostic procedures and medical treatment as ordered by the attending physician. Resident authorizes the attending physician his/her assistants, and the licensed nursing staff to administer and perform all necessary medical nursing treatments. The Resident agrees to maintain a physician appointed by the Resident, as Attending Physician for the Resident, at all times. This appointment may be changed at any time by the Resident with notice to FTJ and the physician.

I understand Franke Tobey Jones has the right to terminate my Residency Agreement if my physical or mental health exceeds the scope of care provided at this community, or in case of medical emergency or imminent danger to resident or others.

_____ _____

Printed Name of Resident Date

_____ _____

Signature of Resident/Responsible Party Date FTJ Representative Date

If signature by an authorized representative, print name and relationship to the resident.

_____ _____

Printed Name of Authorized Representative Relationship/Date

FRANKE TOBEY JONES
Enjoy your age

Future Resident's Health History

Name of Resident _____ Date _____

1. How would you describe your Health Status in the last 90 days? (check one)

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Your best guess at your current weight: _____ Current height: _____

3. Has your weight increased or decreased by more 10 pounds?
   in the last 6 months?..... ☐ No ☐ Yes

4. Do you have any limitations on your activity?..... ☐ No ☐ Yes
   a. If yes, what kind of limitations? (i.e. bathing, dressing, toileting, medications, etc.)

   _____

   _____

   b. Please check any of the following that apply to you:

   ☐ Shortness of breath ☐ Need for oxygen
   ☐ Low energy ☐ Hard to get out of a chair
   ☐ Hard to walk on uneven ground ☐ Pain limits my activity
   ☐ I consider myself physically fit

5. Do you have any physician prescribed dietary needs? ☐ No ☐ Yes
   a. If yes, please describe (your food preferences will be collected in the Interest Profile):

   _____

   b. Do you have any difficulty swallowing? ☐ No ☐ Yes

6. Have you had a fall within the last 6 months? ☐ No ☐ Yes
   a. Did it result in injury? ☐ No ☐ Yes

7. Do you use a walker or wheelchair? ☐ No ☐ Yes
   a. If yes, which do you use and how often?

   _____

8. Do you have any limitations in any of the following?

   Hearing? ☐ No ☐ Yes Do you use aids? ☐ No ☐ Yes
   Vision? ☐ No ☐ Yes Do you use aids? ☐ No ☐ Yes
   Taste? ☐ No ☐ Yes

9. Have you had any problems with your skin? ☐ No ☐ Yes
   a. If yes, please describe (i.e. chronic rashes, skin irritants, etc.):

   _____

   _____

10. Do you have chronic infections? ☐ No ☐ Yes
   a. If yes, how is it being treated?

   _____

   _____

11. Have you had a flu shot? ☐ No ☐ Yes Date: _____
   a. Have you had a pneumovax immunization? ☐ No ☐ Yes Date: _____

12. Have you been hospitalized in the past year? ☐ No ☐ Yes
   a. If yes, please describe the reason:

   _____

   _____

   _____

   b. Where?

   _____

13. Do you have a pacemaker? ☐ No ☐ Yes

14. Do you have anyone helping you at home with any of the following:
   a. Jobs around the house? (cleaning, yard work, making meals, laundry, etc.) ☐ No ☐ Yes
   b. Shopping or getting to personal appointment? ☐ No ☐ Yes
   c. Your personal care? ☐ No ☐ Yes

15. Please indicate if you have experienced any of the following in the past 6 months:
   a. Episodes of anxiety? ☐ No ☐ Yes
   b. Episodes of depression? ☐ No ☐ Yes
   c. Reduced desire to eat or take medication? ☐ No ☐ Yes
   d. Substance abuse? ☐ No ☐ Yes
   e. Changes in sleep patterns? ☐ No ☐ Yes
   f. Difficulty concentrating on a specific task? ☐ No ☐ Yes
   g. Trouble remembering recent events? ☐ No ☐ Yes
   h. Trouble remembering things from the past? ☐ No ☐ Yes
   i. Difficulty finding words or finishing a thought? ☐ No ☐ Yes

_____ _____

Signature of person completing form Please Print Name & Relationship/ Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS:

PATIENT INFORMATION:

Name (print): DOB SSN

INFORMATION TO BE RELEASED FROM:

Name of facility or provider:

Address: Phone: Fax:

INFORMATION TO BE SENT TO:

Name of facility or provider:

Franke Tobey Jones Retirement Community
5340 N. Bristol ST. Tacoma, WA 98407 **(253) 752-6621 phone**
(253) 756-1862 Main Fax

INFORMATION TO BE RELEASED:

___X___ History & Physical (within 1 yr.)
___X___ Medication Profile (MAR) w/diagnosis ___X___ POLST
___X___ Nurse's progress Notes
___X___ Therapy Notes

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

__X___ Admission _____ Attorney _____Insurance _____Doctor

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

_____ *HIV/AIDS diagnosis/treatment & testing ____*Sexually transmitted diseases
_____ *Mental illness or Psychiatric diagnosis/treatment ____*Drug/Alcohol abuse/treatment & diagnosis

MY RIGHTS:

I understand I do not have to sign this authorization in order to get health benefits (treatment, payment or enrollment). I may revoke this authorization at any time. If I do, I will be required to revoke this authorization in writing and present to the FTJ Privacy Officer. To review the process for revoking this authorization, please read the Privacy Notice at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. If I have questions about the use or disclosure of my health information, I may contact the Sr. Director of Clinical Services or the Facility Administrator.

_____ _____
Signature of resident or authorized representative Date (expires 90 days after signing)

_____ _____
Printed name of resident representative (If applicable) Relationship

DR LEONICO PANLASIGUI or DR AMIR ARREF
253-350-7038
206-955-0571

CONSENT FOR MEDICAL TREATMENT

1. **Consent to treat:** I hereby consent to medical treatment, procedures, x-rays, laboratory tests and other health care services. I, patient/patient representative, understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree, in general, to permit x-rays, laboratory tests, routine medical and mental health treatment (for example: medications, injections, drawing blood for tests, counseling, screen tests and other diagnostic procedures) as necessary to be performed at the request of Dr. Panlasiqui.

2. **Assignment of benefits:** I hereby authorize my insurance carrier(s) or third party benefits available for health care services to direct payment of medical benefits, if any, be made to the aforementioned provider on my behalf for any unpaid services rendered. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

3. **Release of records:** I hereby authorize the above-mentioned individuals to obtain information and copies of records pertaining to my medical care. I authorize the release of medical information to my health plan(s) for information requested by the health plan to determine the medical benefits. The information authorized for release may include information about communicable and non-communicable disease, mental health, substance or alcohol abuse.

4. I, patient/patient representative, understand and agree that I am ultimately responsible for the balance on my account for any professional service rendered. Medicare rules and insurance agreements may affect patient responsibility for the account. I will notify you of any change in my insurance status.

5. I am the patient or am authorized to sign this agreement. I have received a copy of it and accept its terms. _____ (initials.)

_____ _____ _____
Signature of Patient or Legal Representative Date Relation

_____
Name of Legal Representative

_____ _____ _____
Patient Name DOB Facility

Omnicare Pharmacy Services

RESIDENT ADMISSION RECORD AND AGREEMENT

Facility Name: Franke Tobey Jones ID # Admission Date Pharmacy Name

Room # Bed Customer ID # Billing Dept. Fax #

RESIDENT INFORMATION

Please verify that all information is correct - ☐ Yes			**☐ No (indicate corrections or missing info.)**	
First Name	Last Name	MI	Preferred Name/Nickname	
Medicare (HICN) #	Date of Birth		Sex ☐ M	☐ F
Physician's Name		Phone Number		
Resident is solely responsible for the financial and legal authorizations and health care decisions: ☐ Yes			**☐ No**	
PRIMARY CONTACT				
First Name	Last Name		Relationship to Resident	
Address	City	State	Zip	Phone
The Primary Contact is the Resident's Legal Representative as defined on the reverse of this form:			☐ YES	☐ NO
The Primary Contact is the Financially Responsible Party as defined on the reverse of this form:			☐ YES	☐ NO
The Primary Contact is responsible for Health Care Decisions as indicated on the reverse of this form:			☐ YES	☐ NO
If the answer to any of the above is no (and the resident is not solely responsible), then please provide contact information below where indicated.				
LEGAL AND FINANCIALLY RESPONSIBLE PARTY INFORMATION				
First Name	Last Name		Relationship to Resident	
Address	City	State	Zip	
Legal Representative is also Financially Responsible Party: ☐ Yes ☐ No **If NO, please list Financially Responsible Party below:**				
First Name	Last Name		Relationship to Resident	
Address	City	State	Zip	Phone Number
Legal Representative or Financially Responsible Party (circle one) is also responsible for Health Care Decisions: **☐ Yes ☐ No If no, please provide contact information below.**				
First Name	Last Name		Relationship to Resident	
Address	City	State	Zip	Phone Number

PAYMENT SOURCES FOR PHARMACY PRODUCTS AND SERVICES

Please verify that all information is correct - ☐ Yes ☐ No (indicate corrections or missing information)

To assist in billing for medications and services provided to the Resident during their stay, please verify and/or check sources that apply:

NOTE: If your nursing facility stay is covered under Medicare Part A OR you are dual eligible (Medicare Part D and Medicaid coverage), you should not be billed for medications provided by our pharmacy, once your coverage has been verified. However, are billing Medicare Part D on your behalf and you have not been a resident of the facility for a full month, there may be color the first month's medications after the reimbursement from the Part D Plan.

Self-Medicare-A (Effective Date:) Medicare-B (Effective Date)
Medicare-D Plan Name Member ID BIN/PCN Group #

Medicaid # State Effective Date

Other Insurance: Name Number

Hospice Phone No Veteran Drug Benefit or Other

(Please describe "other" and provide pharmacy with copies (FRONT and BACK) of ALL Drug Coverage Cards.)

Authorization for Payments by the following methods (see #4 under Terms of Agreement)

Credit Card Credit Card No
Name as it appears on card Exp. Date (MM/YY) Security Code

Bank Account Transfer: Name of Bank
Acct. # Routing Number

City	State	Zip

By signing below, the Resident or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the terms described on the back of this document.

Resident/Legal Representative Name (Please Print) Signature Date

Financially Responsible Party Name (Please Print) Signature Date

NOTE: If Resident **has personally signed**, it is not necessary to complete the information below. If the Resident is **physically unable to sign**, an authorized Representative (other than the Legal Representative) may sign on his/her behalf, but must complete all information, including the Resident's medical reason for an inability to sign. By allowing a person other than the Legal Representative to sign, the Resident agrees to and is bound by all of the terms of this agreement. Medical Reason for Resident's Inability to sign:

Authorized Representative's Relationship to Resident:

Street Address City, State and Zip Code