☐ Date_____
☐ APP FEE in
☐ Copy of Cards
☐ Copy FPOA/ MPOA
☐ Copy POLST
☐ Financials
☐ Scanned to MR
☐ Fax Medical ☐ FD
☐ Assessment
☐ Keys, Card, Mail
☐ Blue #____
☐ Name Plate:

_____

1st	2nd
☐ LP	☐ LP
☐MC	☐MC

☐ Counselor_____
☐ Timeline _____
☐ From_____
☐ Apt. # _____

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 503© for persons 62 years or older that meet the financial and health requirements. A one-time application fee of $1000 (per person) must accompany this completed application. The application fee is refundable when the prospective resident withdraws the application while on the waitlist, as long as it is in the first seven (7) years of the date your application was submitted. The fee would also not be refundable once an assessment is completed by the clinical staff. Assessments are only scheduled for prospective residents moving to a care area of campus. A Refund must be requested in writing, addressed to the Director of Resident Accommodations.

An incomplete application may delay your admission.

Name _____
(First) (Middle) (Last) Home phone

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

cell 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

Military Service: ❍ Air Force ❍ Army ❍ Coast Guard ❍ Marines ❍ Navy
Religion: (if you want to disclose) _____

Social Security # _____ Medicare # _____

Medicare Supplemental Insurance Provider _____

Subscriber # _____ Group # _____ Phone # _____

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

❍ Driver's License/ID ❍ Medicare Card (NEW) ❍ 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/Culture
- ☐ Church
- ☐ Cards/Board Games
- ☐ Food/Cooking
- ☐ Cycling
- ☐ Dancing
- ☐ Fitness/Sports
- ☐ Knitting/Sewing/Quilt
- ☐ Gardening
- ☐ Golf
- ☐ Movies
- ☐ Music
- ☐ Painting
- ☐ Pets
- ☐ Photography
- ☐ Reading
- ☐ Sporting Events
- ☐ Life-long learning/Sr U
- ☐ Traveling
- ☐ Volunteering
- ☐ Walking/Hiking
- ☐ Wine/Beer
- ☐ Writing/Journaling
- ☐ Woodworking

Medical Contacts

You must have a local (Pierce County) Primary Care Physician and must have been seen in the last 12 mos. We cannot admit to AL or MC without this information.

Primary Physician (PCP)_____
(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 placed 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

Valid Driver's Car information: must have a working, drivable car with a valid DL for a parking space.

❍ Year_____ ❍ Make_____ ❍ Model_____

❍ Color_____ ❍ Plate #_____ ❍ DL #_____

FRANKE TOBEY JONES
Enjoy your age

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 whom have lived here for a long time and may 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 through the Finance Department. 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 provide personal financial information to Franke Tobey Jones at admission.

Long Term Care Insurance

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

___ I elect to disclose the financial information and 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.

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
_____	$_____
_____	$_____

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

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

Total Assets $_____

Mortgage Balances/Debts/Liabilities/Credit Card Balances

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

Total Liabilities $_____

_____
Applicant Name

_____ _____
Applicant Signature Date

FRANKE TOBEY JONES
Enjoy your age

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

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 (you need to see your PCP within the last year)

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

Omnicare* Resident Pharmacy Enrollment Form

A CVS Health Company

Community Name* Franke Tobey Jones **Room Number (if Available) _____**

Move-in Date* _____ Future Admit O Yes O No

Resident Information

*Required Field

Last Name" (Please Print) | First Name* | Middle Initial

Date of Birth (MM/DD/YYYY) | Phone Number* | Gender

Street Address* (for billing purposes) | City* | State* | Zip*

Social Security Number* | Medicare ID Number*

Physician Name* | Physician Phone Number*

Known Allergies* O No Known Allergies

Is Omnicare the Resident's Primary Pharmacy? O Yes O No

Are the Resident's medications managed by community O Yes O No (self-administered)

Is the Resident responsible for all pharmacy services, including the bill and any other finances?

O Yes O No (IF NO, PLEASE COMPLETE THE NEXT SECTION BELOW)

Financially Responsible Party

Only complete if there is a Responsible Party, other than the Resident, who agrees to be responsible for payment of all amounts owed by the Resident for prescription drug products and services provided to the Resident by Omnicare.

Responsible Party Last Name* (Please Print) | Responsible Party First Name*

Date of Birth (MM/DD/YYYY) | Phone Number* | Gender

Billing Address* | City* | State* | Zip*

People involved in the Resident's health care

The following people are involved in the Resident's health care and have permission to manage the Resident's prescriptions.

Full Name_____ Phone Number_____

Circle all that apply:

Same as Financially Responsible party | Legal Guardian POA | Legal Guardian by court order

Spouse | Child | Other_____

Payment sources for pharmacy products and services

Does the Resident have prescription insurance coverage?* O Yes O No

Please circle all sources that apply:

O **Medicare Part B**

Effective Date: _____

Medicare Part B Number: _____

O **Medicare Part D or Rx Insurance**

(Commercial) Plan Name

Plan Name: _____

ID Number: _____

Group Number: _____

BIN/PCN: _____

Phone Number: _____

O **Medicaid**

Number: _____

State: _____

Date: _____

O **Hospice**

Hospice Name: _____

Phone Number: _____

O **Veteran Drug Benefit**

Name: _____

Signature

By signing below, the Resident or Resident's Representative acknowledges and agrees as set forth below.

_____

Resident Signature / Representative Signature*

_____

Printed Name Date

For Residents living in the state of Massachusetts:

O Controlled Substances in MultiDose packaging: The Resident or Resident's caregiver (e.g., responsible party) authorizes the ability to package controls in MultiDose packaging with other medications. This packaging is not child resistant. Please check the box to indicate that you read and understood this.

Omnicare Prescription Medication Service Terms

1. Prescription Containers: Resident understands that the prescription drug products provided by Omnicare will be dispensed in containers that are not child resistant.
2. Legal Representative: Any individual signing on behalf of Resident and representing that they are the Resident's Guardian or Legal Representatives ("Representative") will provide Omnicare with documentation establishing his/her legal authority to enter into this Agreement. If this Agreement is executed by the Representative, the Representative hereby affirms that s/he has the authority to enter into Agreements on the Resident's behalf. References in these Service Terms to "Resident" will include the Representative, as appropriate.
3. Assignment of Benefits: Resident hereby requests and authorizes any third-party payer to make payment directly to Omnicare for products and services provided to the Resident. Resident will immediately notify Omnicare in writing of any change to the Resident's ability to make health care decisions independently or change in Representative.
4. Payment: Payment in full amount owed by Resident is due within 30 days of the invoice date, and a finance charge equal to the lesser of 1.5% per month or the maximum rate permitted by law may accrue on all delinquent accounts beginning on the day after the payment is due.
5. Fees and Expenses: The Resident and/or Financially Responsible Party are responsible for paying all costs and expenses incurred by Omnicare in the collection of amounts owed and the enforcement of its rights under this Agreement, including without limitation, attorneys' fees, court costs and expenses.
6. Delinquent Payment: The Resident and/or Financially Responsible Patty acknowledge that if the Resident is delinquent on payment of any amount owed to Omnicare, Omnicare may, in its sole discretion, (a) condition its continued provision of products and services to the Resident upon Omnicare's receipt of assurance of payment acceptable to Omnicare, which may include, without limitation, a requirement that Omnicare receive authorization to charge all amounts owed, past and future, to a valid credit card number; and/or (b) suspend or terminate its provision of products and services to the esident. Such suspension or termination will in no way affect the obligation to pay all amounts owed under this Agreement, including costs of collection.
7. Successors: This Agreement shall inure to the benefits of, and be binding upon, each party and its respective affiliates, successors and assigns, heirs, executors, and administrators.
8. Disclosure or Use of Resident Information for Treatment, Payment, and Healthcare Operations. The Resident or Legal Representative hereby acknowledges Omnicare has made available a copy of its Notice of Privacy Practices and that Omnicare may use and disclose Resident's personal health information in compliance with Federal and state laws.
9. People listed as being involved in resident's healthcare have permission to perform activities necessary to manage resident's prescriptions, including, but not limited to, submitting prescriptions to be filled, viewing resident's prescription records and medical profile, discussing resident's care with Omnicare pharmacists, accessing financial information related to resident's prescriptions, providing guidance and direction to Omnicare pharmacy in connection with resident's prescriptions, and/or undertaking any activity that resident personally could undertake to manage resident's prescriptions. Resident's Caregiver may manage resident's prescriptions in person at Omnicare pharmacy, telephonically, or through any other channel that Omnicare pharmacy makes available. This consent is valid until revoked on by telephonically calling 866-397-8935.
10. Minnesota residents: Controlled substance prescriptions (Schedules II-V, butalibital and gabapentin) dispensed at this pharmacy are reported to the Minnesota Prescription Monitoring Program as required by Minnesota Statutes Section 152.126 and may be used for program administration purposes. pmp.pharmacy.state.mn.us
11 -Minnesota residents: in order to save you money, this pharmacy will substitute whenever possible an FDA-approved, less expensive, generic drug product, which is therapeutically equivalent to and safely interchangeable with the one prescribed by your doctor, unless you object to this substitution.

FRANKE TOBEY JONES
Enjoy your age

AUTHORIZATION TO RELEASE MEDICAL RECORDS:

PATIENT INFORMATION:

Name (print): DOB

INFORMATION TO BE RELEASED FROM:

Name of Primary Care Physician/Facility:

Address: Phone: Fax:

INFORMATION TO BE SENT TO:

Name of facility or provider:

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

INFORMATION TO BE RELEASED:

___X___ History & Physical (within 1 year)
___X___ Medication Profile (MAR) w/diagnosis ___X___ Signed Current Medication list
___X___ POLST

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

FRANKE TOBEY JONES
Enjoy your age

Assisted Living Medication Management

Assisted Living residents obtaining prescriptions and over-the-counter supplies at outside pharmacies are solely responsible for ordering and obtaining their prescription supplies. Franke Tobey Jones staff will assist in notifying when medications/supplies are running low but will not be available to pick-up prescriptions from the pharmacy.

For residents who are utilizing OmniCare, the nursing staff will manage their refill supplies solely from OmniCare.

If you choose to use a pharmacy other than OmniCare, please complete the following information regarding prescription ordering and return to the Assisted Living nursing staff or Admissions team.

Pharmacy of choice: _____

Phone Number: _____

Person to contact when prescriptions are needed:
_____

Person who will be delivering these prescriptions to the facility:
_____

Alternate contact for prescription ordering and supplies:
_____

If you wish to transfer prescriptions to OmniCare, please notify the nursing staff or Social Worker for the appropriate enrollment information.

Thank you for choosing Franke Tobey Jones for your care needs.

Thank you,
Holly Elton
Resident Care Supervisor, Assisted Living
253-756-6227