☐ Date___________
☐ APP Fee N/A
☐ Copy of Cards
☐ Copy of COVID card
☐ Copy FPOA/ MPOA
☐ Copy POLST
☐ Financials
☐ Copies (3) ☐ FD
☐ Fax Medical
☐ Records Rec'd.
☐ Assessment date_______
☐ Move-in date__________
☐ _____________

FRANKE TOBEY JONES
Enjoy your age

☐ SN

☐ Counselor________
☐ Timeline __ASAP___
☐ From____________
☐ SN RM # _________
☐ Blue#____________

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, except SN) 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) (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

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 ❍ POLST ❍ COVID Vaccine Card
❍ 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 Community (if at one) ____

Contact person at Community____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 Tasting
- ☐ Writing/Journaling
- ☐ Woodworking

Medical Contacts

(Records must be no more than 12 mos. old, if you haven't seen your PCP in the last year, please make an appointment)

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

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 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:

___ 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 | Current Balance Due

Description

____ $________________
____ $________________
____ $________________

Total Liabilities $______________

____
Applicant Name

____
Applicant Signature or POA

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

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

____

Printed Name of Authorized Representative Relationship/Date

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 FOR ADMISSION:

Name (print): DOB SSN (last 4)

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) 756-1862 Main Fax** **(253) 752-6621 phone**

INFORMATION TO BE RELEASED:

___X___ History & Physical (within 1 yr.)
___X___ Medication Profile (MAR) w/diagnosis
___X___ Nurse's progress Notes
___X___ Therapy Notes
___X___ POLST
___X___ Doctor's Order to Admit to SN
___X___ Signed Medication Order

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
_____ *Mental illness or Psychiatric diagnosis/treatment
____*Sexually transmitted diseases
____*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

_______________________________________ __________ _Franke Tobey Jones_______________
Patient Name DOB Facility

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.