



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. No application fee is needed to get on the wait list for the Care Areas. There is however, a \$5000 Community Fee (non-refundable) due upon occupancy of an apartment. Assessments are only scheduled for prospective residents moving to a care area if we have availability. FTJ may choose to shred this Application after a year, unless there is communication with Admissions.

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? _____

- 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:

- LP
- MC

- Counselor _____
- Timeline _____
- From _____
- Apt. # _____
- Medical Records in?
- Assessment
- LOC _____
- \$5k Comm. Fee PP

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:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Arts/Culture | <input type="checkbox"/> Gardening | <input type="checkbox"/> Sporting Events |
| <input type="checkbox"/> Church | <input type="checkbox"/> Golf | <input type="checkbox"/> Life-long learning/Sr U |
| <input type="checkbox"/> Cards/Board Games | <input type="checkbox"/> Movies | <input type="checkbox"/> Traveling |
| <input type="checkbox"/> Food/Cooking | <input type="checkbox"/> Music | <input type="checkbox"/> Volunteering |
| <input type="checkbox"/> Cycling | <input type="checkbox"/> Painting | <input type="checkbox"/> Walking/Hiking |
| <input type="checkbox"/> Dancing | <input type="checkbox"/> Pets | <input type="checkbox"/> Wine/Beer |
| <input type="checkbox"/> Fitness/Sports | <input type="checkbox"/> Photography | <input type="checkbox"/> Writing/Journaling |
| <input type="checkbox"/> Knitting/Sewing/Quilt | <input type="checkbox"/> Reading | <input type="checkbox"/> 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.

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 # _____



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:	1 st Person	2 nd 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



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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



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:

- | | |
|---|---|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Need for oxygen |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Hard to get out of a chair |
| <input type="checkbox"/> Hard to walk on uneven ground | <input type="checkbox"/> Pain limits my activity |
| <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you use aids?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Vision?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you use aids?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Taste?	<input type="checkbox"/> No <input type="checkbox"/> 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



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:

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

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

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

Mercury Pharmacy Services, Inc.22316 70th Ave W, Suite 5
Mountlake Terrace, WA 98043

Ph: 425-673-5200 or 1-800-323-6081

Fax: 425-673-5230 or 1-800-323-6082

Revised: 04/22/21

Pharmacy Agreement**REQUIRED:** I want to use Mercury Pharmacy for ALL OF MY MEDICATIONS EMERGENCIES ONLY

Facility: _____ *

Resident Name: _____ * Admit Date: _____ *

Date of Birth: _____ * Allergies: _____ *

Social Security #: _____ * Primary Physician _____ *

REQUIRED: Insurance for Prescription Coverage

Name of Plan: _____ Medicaid Y/N: _____

(Please provide copies of both front and back of card)

REQUIRED: Financially Responsible Party

Responsible Party: _____ Relationship: _____ POA Y/N _____ Billing Address: _____ City/State: _____ Zip: _____ Phone: _____ Email: _____	OR Bill the Resident at the facility: <input type="checkbox"/> Apt _____ Email bills only: <input type="checkbox"/> E-mail: _____
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AUTOPAY SIGN UP – Must be completed in full. (Optional):I authorize Mercury Pharmacy to charge my debit/credit card each month.Visa MasterCard American Express Discover

Credit Card #: _____

Exp Date: _____

Name on Credit Card: _____

Security Code: _____ Zip Code: _____

I authorize Mercury Pharmacy to charge my bank account each month.

Routing #: _____

Account #: _____

Name on Acct: _____

Mercury Pharmacy Services is dedicated to servicing the pharmacy needs of Long-Term Care Facilities. Our service includes specialized packaging for the residents, charge accounts, and deliveries. I understand that the community staff will be ordering and accepting delivery of medications on my behalf. This facility uses a unit dose system of drug packaging. It is necessary that all drugs in this facility conform to this system so that efficiency and accuracy are maintained per facility policies. Upon discharge, only those medications authorized by the resident's physician will be released to the resident or responsible party. Discontinued medications or medications remaining after the death or discharge of a resident will be disposed of per facility policies. Controlled drugs should be destroyed by the nursing staff as per licensing regulations. By signing this agreement, I accept all charges from Mercury Pharmacy and agree to pay them. For private pay residents, all pharmacy charges are **due on the date listed on our invoice**. All payments are to be made directly to Mercury Pharmacy Services. Accounts over 30 days delinquent are subject to bearing a monthly interest at a rate of 1.5%. Should the account be referred to collection the undersigned agrees to pay costs of collection, including reasonable attorney fees. Mercury Pharmacy Services reserves the right to discontinue providing medications to any account that is over one-hundred twenty (120) days delinquent. NSF check charges are \$25.00 plus any collection costs. By signing this agreement, I authorize Mercury Pharmacy Services to bill Medicare or other insurances for the above patient if applicable. I also authorize Mercury Pharmacy Services to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable of related services. Blister packaging is not child proof. I request that the pharmacy fill my medication in non-childproof containers (i.e., Blister packs or easy open vials). By signing this agreement, the undersigned has acknowledged that they have received a copy of our privacy policies and has reviewed them. The undersigned accepts the terms of this agreement as stated above. I certify that I have the authority to sign this document for the resident named above.

Signature: _____ Please print name: _____ Date: _____