☐ Date_____
☐ APP Fee N/A
☐ Copy of Cards
☐ Copy FPOA/ MPOA
☐ Copy POLST
☐ Financials
☐ Copies (3) ☐ FD
☐ Fax Medical
☐ Records Rec'd.
☐ H & P, Order to Admit
And signed med list.
☐ Assessment date_____
☐ Move-in date_____
☐ _____

☐ SN

☐ Counselor_____
☐ Timeline __ASAP___
☐ From_____
☐ SN RM # _____
☐ Blue#_____

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, Private Pay, CCRC 501©3 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.

Assessments are completed prior to admission and only scheduled for prospective residents 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) (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

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

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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.

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

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

Total Liabilities $_____

_____
Applicant Name

_____
Applicant Signature or POA

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 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

FRANKE TOBEY JONES
Enjoy your age

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___ Doctor's Order to Admit to SN
___X___ Signed Medication Order
___X___ Medication Profile (MAR) w/diagnosis
___X___ Nurse's progress Notes
___X___ Therapy Notes
___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
_____ *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

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: ☐ Apt _____

Email bills only: ☐

E-mail: _____

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:** _____

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