

Application for Admission

Martha Franks, a Christ-centered Retirement Community
1 Martha Franks Drive
Laurens, SC 29360

Note: Please answer all questions as completely and accurately as possible. All information released will remain confidential.

Full Name: _____

Address: _____

Phone: _____

How long have you lived at this address: _____ Date of Birth: _____

Are you married _____ If yes, date of marriage: _____

Widowed _____ If yes, date of spouse's death: _____

Name of spouse: _____

With whom are you living now: _____

List your children:

Name	Address
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Occupation prior to retirement: _____

Spouse's occupation prior to retirement: _____

How far did you go in school? _____

List college / graduate schools: _____

List talents or hobbies: _____

How did you hear about Martha Franks Baptist Retirement Community? _____

What church are you a member of: _____

Address: _____

Pastor's name: _____

List the companies and amounts of life insurance you carry:

Company:	Amount:	Beneficiary:
_____	\$ _____	_____
_____	\$ _____	_____

Are you the beneficiary of a life insurance policy? _____

Company:	Amount:	Beneficiary:
_____	\$ _____	_____
_____	\$ _____	_____

List your hospitalization insurance:

Company: _____	Policy # _____
Company: _____	Policy # _____

List any Long Term Care Insurance:

Company: _____ Amount \$ _____ Duration: _____

Do you have a living will? YES ____ NO ____ If so please attach a copy
Do you have a General Power of Attorney? YES ____ NO ____ If so please attach a copy
Do you have a Durable Power of Attorney? YES ____ NO ____ If so please attach a copy
Do you have a Health Care Power of Attorney? YES ____ NO ____ If so please attach a copy
Do you have a will? YES ____ NO ____ Executor's name _____

Is your need to enter Martha Franks urgent? YES ____ No ____
At what approximate date would you like to enter the facility? _____
What type of accommodations would you be interested in?
 Studio Room 2-Room Suite Cottage Apartment Patio Home

I make this application for residency at Martha Franks Baptist Retirement Community of Laurens, South Carolina, of my own free will and accord. I declare the answers to the foregoing questions to be true, full, and complete.

Date: _____ Signature: _____

Martha Franks Baptist Retirement Community

Financial Statement

Martha Franks Baptist Retirement Community respects the privacy of every applicant and will hold the enclosed financial information in strict confidence. To assure Martha Franks Baptist Retirement Community continued solvency and in keeping with the trust imposed upon it, Martha Franks requires and expects all residents to pay the scheduled charges to the full extent of their financial resources and ability and not to deplete those resources in any way that would jeopardized this ability.

Name: _____

Address: _____

Financial			
<i>Assets</i>			
	Life Insurance		
	Real Estate		
	Savings & CD's		
	Checking		
	Stocks/Mutual Funds		
	Total		
<i>Income</i>		<i>Monthly</i>	<i>Annual</i>
	Social Security		
	Annuity		
	Pension		
	Other		
	Total		\$

Do you owe any debts? Yes___ No___ Amount \$_____

Are any debts owed to you? Yes _____ No _____ Amount\$_____

By whom? _____

How secured? _____

Martha Franks Baptist Retirement Community

Personal Health History

It is important for both Martha Franks Baptist Retirement Community and the Applicant that a full medical listing be established so that the doctors and nurses entrusted with the care of the resident may be well advised. This medical record is in two parts, a Personal Health History to be filled in and submitted by the Applicant, and the Physician's Report and Examination to be submitted later by a doctor.

Martha Franks realizes that all applicants have had various illnesses in the course of their lives, and that most will have some infirmity when applying; however, acceptance of an application is not conditioned on perfect health.

1. Full Name _____
2. Date of Birth _____ Place of Birth _____
3. Estimate in your own words the condition of your health _____

4. Describe any chronic diseases (heart, diabetes, kidney, etc.) _____

5. Specify any physical limitations or deformities (glasses, hearing aids, arthritis, etc.) _____

6. Do you require assistance with the following: Dressing _____
Personal Care _____ Walking _____ Personal Laundry _____
Do you drive _____ Do you plan to bring your car with you? _____
7. Describe any allergy, including reactions to drugs _____

8. Describe any surgical operations, serious illnesses, and hospitalization, within recent years, giving dates (years) _____

9. Have you ever had the following, with what treatments and results:

Tuberculosis _____

Cancer _____

Nervous breakdown _____

Recurring headaches _____

Anemia _____

Polio _____

Stroke _____

10. Are you able to get to the Dining Room with out assistance? _____ Do you have any special diet? _____

11. Are you presently under special medical care _____ if so, for what? _____

12. What special medicine, vitamins, and drugs are you now taking? _____

13. Do you currently have medical insurance : Hospital _____
Health _____ Physician _____ Medicare _____

14. Your physician's name _____
Address _____

Telephone () _____

15. I herby authorize my physician to release medical information to Martha Franks Baptist Retirement Community for purposes of application and residence.

Date _____ Signature _____

Martha Franks Baptist Retirement Community

Physician's Report and Examination

To the examining physician: Martha Franks Baptist Retirement Community is a Continuing Care Retirement Community with three levels of care. It is important that this report be complete so that the resident can be placed in the appropriate accommodations to insure that the optimum level of care is provided.

1. Applicant's full name _____
2. Health History _____

3. General impression of examinee's health (good, fair, poor) Physical _____
Mental Status _____ Weight _____ Height _____ Temperature _____
Muscular Development _____ Posture _____ Spinal Deviation _____
Does the applicant require the assistance of a nurse? _____
Is the applicant able to self-administer medications? _____
4. Head and Neck:
Eyes: by Snellen test type report vision: w/o glasses R _____ L _____
W glasses R _____ L _____
Any other eye abnormality _____ Tension _____ Cataract _____
Ears: (a) Hearing R _____ L _____ (b) Pain, Discharge, etc _____
(c) Appearance of drums _____
Nose: (a) Obstructions _____
(b) Sinuses or other conditions _____
Mouth: (a) Gums _____ Tongue _____
(c) Teeth condition _____ Dentures: Upper () Lower ()
Lymphatic gland _____
Thyroid _____
5. Chest: Deformities _____ Breasts _____
Lung Findings _____
Cardio-vascular: (a) Heart: Record size, action, murmurs, compensation etc. _____
(b) Electrocardiogram (if indicated) _____
(c) Pulse quality _____ (d) Regularity _____

(e) Pulse Rate (sitting) _____ (f) Blood Pressure (sitting) _____
(Standing) _____ (lying) _____

6. Abdomen:

Tenderness _____ Scars _____
Masses of resistance _____
Hernia _____
Are spleen, liver or kidneys palpable? _____

7. Extremities:

Varicose veins _____ Edema _____
Paralyses, atrophies, deformities _____
Pulses _____

8. Cutaneous System:

Is there any rash, eruption, or other skin pathology? _____

9. Neuro-Psychic:

Is examinees nervous and mental system stable and sound? Consider
fatigue, irritability, emotionalism, depression, headaches, insomnia?

Any tremors present? _____
What is the condition of knee jerks? _____
Papillary reaction to light? _____

10. Genito-Urinary System:

Does urinary system or external genitals show any pathology? _____
Pelvic examination (if indicated) _____
Size and condition of prostate gland _____

11. Laboratory Findings:

Blood: (a) Complete count _____ (b) Fasting sugar _____
Urine: (a) Specific gravity _____ (b) Reaction _____ (c) Albumen _____
(d) Sugar _____ (e) Microscopic finings _____
X-rays (if indicated) _____
Other Examinations _____

12. Summary:

Do you recommend the applicant for admission to Martha Franks Baptist
Retirement Community? _____ All significant positive historical and
physical findings _____

Physicians Name (Print) _____ Signature: _____ Date _____

TO WHOM IT MAY CONCERN

PATIENT'S NAME: _____

_____ **This is to certify that the patient named above in my professional judgment is competent to administer his/her own medication.**

_____ **Although not competent to administer his/her own medications is physically and mentally capable of living in the Boarding Division of Martha Franks Baptist Retirement Community.**

DATE

Signature of Physician

Those Residents not deemed competent to administer their medications, but who are otherwise capable of living in the Boarding Division of Martha Franks Baptist Retirement Community, will have all prescription medications administered by licensed personnel in accordance with physician's orders.