13. If admitted to Friendship Retirement Community, do you agree that neither Friendship Retirement Community nor any member of the staff or the Board of Directors will be held liable for any accident or injury that you may sustain during your residence in Friendship Retirement Community if the accident or injury is not due to direct negligence on the part of Friendship Retirement Community? . . . . . ☐ Yes ☐ No

If and when you require the services of our special care areas or home health care, do you agree to use these services at the direction of the physician or administration? . . . . . ☐ Yes ☐ No (These may be either private or semi-private.)

If special care is required, are you willing to pay the additional costs involved? . . . . . ☐ Yes ☐ No

AGREEMENT: If my application is accepted, admission to Friendship Retirement Community shall be made subject to the following conditions:

A. That I shall abide by all regulations of Friendship Retirement Community at all times.
B. That in the event of my failure to conform to any of the regulations, I shall peacefully withdraw from Friendship Retirement Community upon notice from Administration.
C. If this application contains an untruth with reference to any statement, answers, representation or description therein, it shall be sufficient reason for the forfeiture of any rights and privileges as a guest in Friendship Retirement Community, and immediate expulsion there from.

Signature_____ Date_____

CONSENT TO RELEASE MEDICAL INFORMATION

Friendship Retirement Community, Inc., Friendship Apartment Village Corporation, Friendship Assisted Living, Inc., Friendship Health and Rehab Center, Inc., Friendship Pharmacy, and Friendship Home Care, hereinafter referred to as "Friendship Retirement Community":

I hereby consent to the release of my protected health information from the designated records set for the purposes of treatment, payment, or health care operations to the following persons: the appropriate Company personnel, attending physicians and consultants; any person or firm responsible for all or any part of the payment or reimbursement of the charges, including any utilization review or quality assurance reviews or payment audits performed by such person or firm; the personnel of the hospital or other facility to which I may be transferred; the Company's liability insurance carrier; person's authorized by law to review the records; others as necessary for treatment, payment, or health care operations; and such other parties as contemplated or authorized by federal and state law.

I understand that I may make a written revocation of this Consent except to the extent that the Company has taken action in reliance on it.

I have received a copy of the Notice of Privacy Practices prior to signing this Consent. I understand that Friendship Retirement Community may revise its privacy practices from time to time and that I may request a copy of the revised Notice of Privacy Practices by contacting the Privacy Officer.

Signature_____ Date_____

NOTE: This application does not obligate Friendship Retirement Community or the applicant in any manner. 10/12

Friendship LIVING

367 Hershberger Road, NW Roanoke, VA 24012 (540) 777-7599

Application for Friendship Assisted Living Admission

Resident # _____ Room # _____ Date of Admission _____

1. Name of Applicant _____ Phone ( ) _____

Email address_____ Cell ( ) _____

Last home address _____

City _____ State _____ Zip _____

Date of Birth___/___/___ Place of Birth: City _____ State _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Gender ☐ Male ☐ Female Social Security #___-___-___

Veteran ☐ Yes ☐ No If yes, which branch?_____ Discharged ___/___/___

To whom shall we send your bill, if other than applicant?

Name _____ Phone number ( ) _____

Address

City _____ State _____ Zip _____

2. Names, addresses, and telephone numbers of children, personal representative, or next of kin.

Name _____ Relationship _____

Email address_____

Address _____

City _____ State _____ Zip _____

Home phone ( ) _____ Work phone ( ) _____

Name _____ Relationship _____

Email address_____

Address _____

City _____ State _____ Zip _____

Home phone ( ) _____ Work phone ( ) _____

3. Your profession, trade or occupation (before retirement if retired) _____

4. Special interests & hobbies_____

Description of family structure & relationships_____

Previous mental health/MR services . . . . . ☐ Yes ☐ No Substance abuse . . . . . ☐ Yes ☐ No

Current behavior & social functioning (strengths/problems) _____

_____

5. With whom and under what arrangement are you now living? _____

_____

_____

6. Have you ever been a resident of any home or institution? . . . . . ☐ Yes ☐ No

If yes, name of institution _____

Address _____

City _____ State _____ Zip _____

Reason for leaving _____

7. Hospital of choice _____

8. Name of physician _____

Address _____

Phone number ( ) _____

Name of dentist _____

Address

Phone number ( ) _____

Name of pastor _____

Address _____

Phone number ( ) _____ Denomination _____

9. Do you have hospital insurance? . . . . . ☐ Yes ☐ No

If yes, company _____ Policy # _____

Do you have Medicare? . . . . . ☐ Yes ☐ No

If yes, Medicare # _____

Do you have long-term care insurance? . . . . . ☐ Yes ☐ No

If yes, company _____ Policy # _____

Have you applied for Medicaid? . . . . . ☐ Yes ☐ No

If yes, when? _____

Do you agree to apply if/when your resources become exhausted? . . . . . ☐ Yes ☐ No

10. Give name, address and telephone number of local Social Services Agency or any other agency and the name of your case manager or case worker (if applicable):

Name of case manager or case worker _____

Name of agency _____

Address _____

Phone number ( ) _____

11. Do you have a power of attorney? . . . . . ☐ Yes ☐ No

If yes, name of power of attorney _____

Email address _____

Address _____

Phone number ( ) _____ (Please provide copy)

Do you have a legal guardian? . . . . . ☐ Yes ☐ No

If yes, name of legal guardian _____

Email address _____

Address _____

Phone number ( ) _____ (Please provide copy)

Have you signed advance directives (living will, DNR, etc.)? . . . . . ☐ Yes ☐ No
If yes, please provide copies.

12. **Burial Arrangements:** Do you have a cemetery lot or right of interment? . . . . . ☐ Yes ☐ No

If yes, give location _____

Do you have a preference of a funeral director? . . . . . ☐ Yes ☐ No

If yes, name of funeral director _____

Address _____

Phone number ( ) _____

RELEASE OF RESPONSIBILITY

Friendship Retirement Community is in no way responsible for any item brought to the facility and if it becomes lost, broken, or in any way no longer useable, it is not Friendship Retirement Community's responsibility to repair, replace, or reimburse.

As the patient's responsible party, I _____, involved with patient/resident, _____, understand that Friendship Retirement Community is released of responsibility of items such as: teeth, glasses, money, and jewelry or any other miscellaneous valuable, as listed below:

_____

_____

_____

_____

Responsible Party _____ Date _____

Admission Representative _____ Date _____