



Dear Potential Resident or Family Member:

Thank you for your interest in Dirigo Pines Retirement Community. All potential residents are asked to complete an Application for Residency and a Medical Release of Information.

These forms are designed to assist us in helping you make your plans. We realize that many of the questions are of a personal nature; therefore we regard your answers as privileged communication and will treat them as a confidential matter.

After reviewing your completed applications and it is determined that Dirigo Pines is appropriate for you, we will contact you to arrange a meeting. Dirigo Pines Retirement Community is committed to serving all eligible and qualified individuals regardless of race, color, gender, disability, or national origin.

If you have any questions, we can be reached at 207-866-3400. We appreciate your interest in Dirigo Pines Retirement Community, and are confident that you have made a good decision.

Cordially,

Steve Bowler, Marketing Director



Application for Residency

I. General Information

Name: _____ Social Security #: _____
Address: _____
City: _____ State: _____ Zip Code _____ How Long at this address? ___yrs.
Telephone: _____ Birth Date: ___/___/___

Gender: Male Female Current or former occupation: _____

Marital Status: (Circle one) Married Single Widow/er

In an emergency, whom should we call?

Name: _____
Address: _____
Phone: _____ Relationship: _____

II. Current Living Situation

Do you currently own your home, or rent? (Circle one) Own Rent

What type of housing do you live in?

Apartment___ Single Family___ Multi-family___ Condo___ Other___

Current monthly rental rate _____

If rental, Name of Landlord/Owner/Manager:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Do you own an automobile? Yes No Make and Year: _____

Do you drive regularly? Yes No Do you intend to maintain a car? Yes No



Application for Residency

Are there any problems or concerns, which our staff should be aware of, or any special support you might need to live in our community? _____

Do you require someone (friend, relative, or other person) to live with you at the present time? If so, who: _____ Reason for this need? _____

If not, do you require someone to visit you during the day? Yes No

If yes, reason for a visit? _____ How long is a visit? _____

Are you considering other housing alternatives? Yes No

If so, which ones? _____

III. Medical and Insurance Information

Primary physician's name: _____

Address: _____ Telephone: _____

Hospital Affiliation: _____

How would you describe your present state of health? _____

How often do you see your doctor? _____ When was your last visit? _____

Are you on any medications at the present time? Yes No If yes, please specify the medication and condition being treated: _____

Do you require assistance to administer the medication? Yes No

Do you prepare your own meals? Yes No If no, who does? _____

Are you on a special or restricted diet? Yes No If yes, _____

Do you have allergies? Yes No If yes, _____

How much walking do you do? _____

Do you have difficulty with stairs? Yes No

Do you use any assistance such as a cane _____, walker _____, or wheel chair _____?

Please list all of your medical insurance coverage, including supplemental and long-term care:

_____ Policy No: _____

_____ Policy No: _____



Application for Residency

III. Level of Ability

Please check the box to indicate your level of ability in the following areas:

| Task | “I can handle this myself” | “I need some assistance.” | Comments |
|----------------------------|-----------------------------------|----------------------------------|-----------------|
| Bathing | | | |
| Dressing | | | |
| Mouth or Skin Care | | | |
| Shaving Grooming | | | |
| Toileting | | | |
| Escort Mobility | | | |
| Medication Reminder | | | |
| Night Care | | | |
| Housekeeping | | | |
| Clothing Management | | | |



Application for Residency

What are your interests? _____

How do you like to spend your time? _____

Is there any other information we should be aware of when reviewing your health and medical concerns? _____

I understand and agree that *this application is neither a contract, nor a reservation for residence*. Nothing contained in these documents is legally binding on either me or the community to which I am applying for residency, until a Residency Agreement has been approved and signed by all parties involved.

Signature of Applicant

Date of Application

Power of Attorney

Completion of this section is voluntary.

In order to help us carry out our responsibilities under applicable Fair Housing Laws, we ask that you identify yourself by one of the following designations: (Please circle only one)

WHITE BLACK HISPANIC ASIAN AMERICAN INDIAN OTHER





Medical Release of Information
Authorization for Disclosure of Protected Health
Information

Doctor Name: _____

Address: _____

Phone: _____ Fax: _____

Resident's Name: _____ Date: _____

Resident's Date of Birth: _____ SS# _____

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with the current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations. I hereby authorize the release of the information checked and/or listed below for the time period beginning on _____ And ending on current date.

- | | |
|--|--|
| <input checked="" type="checkbox"/> Complete health care records | <input checked="" type="checkbox"/> Discharge Summary |
| <input checked="" type="checkbox"/> History & Physical Examination | <input checked="" type="checkbox"/> Progress Notes |
| <input checked="" type="checkbox"/> Minimum Data Set | <input checked="" type="checkbox"/> Care Plans |
| <input checked="" type="checkbox"/> Laboratory Reports | <input checked="" type="checkbox"/> Dental Records |
| <input checked="" type="checkbox"/> Medial/Treatment Records | <input checked="" type="checkbox"/> Photographs, or images |
| <input checked="" type="checkbox"/> Pathology Reports | <input checked="" type="checkbox"/> Emergency Care Records |
| <input checked="" type="checkbox"/> X-Ray Reports | <input checked="" type="checkbox"/> Consultant Reports |
| <input checked="" type="checkbox"/> Transcribed Reports | <input checked="" type="checkbox"/> Immunization Records |
| <input checked="" type="checkbox"/> Nurse's Notes | <input type="checkbox"/> Other: _____ |

This information checked and/or listed above is to be released to: Dirigo Pines Inn, LLC and any consulting providers as authorized by my primary care physician.

I understand that the individual, organization, or entity providing my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.

Unless otherwise revoked by me, I understand that this authorization will expire on: _____, or upon the completion of the use of the information for the purpose it was intended, whichever is earlier.

I understand that I may inspect and copy any information used or disclosed under this authorization.

I hereby release the facility, its employees, officers and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at anytime by providing the facility with my written notice of such revocation.

Date: _____

Resident's Signature: _____

Date: _____

Representative's Signature: _____

Date: _____

Witness's Signature: _____

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FINANCIAL INFORMATION

Please complete the following financial information to assist us in your application process. *Documentation such as form 1040, Bank Statements, Trusts and Powers of Attorney may be required.*

Applicant(s) Name(s):

(First) _____ (MI) _____ (Last) _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: () _____

Date of Birth: ____/____/____

If applying with Spouse, are all assets held jointly? Yes No (If no, complete separate forms)

INCOME SOURCES:

The following worksheet is necessary to determine if your financial resources are adequate to cover the monthly living costs at Dirigo Pines (this information is kept confidential and for internal use only).

Employment Income: \$ _____ per month

Social Security Income \$ _____ per month

Employer Pension: \$ _____ per month

Interest & Dividend Income: \$ _____ per month

Annuity Income: \$ _____ per month

Life Insurance Benefits: \$ _____ per month

Support from family: \$ _____ per month

Rental Income: \$ _____ per month

Other: \$ _____ per month

Total Monthly Income \$ _____



FINANCIAL INFORMATION

Is there any additional information we should be aware of when reviewing your financial resources?

ASSETS:

Please list your assets, including Bank Accounts, Savings Accounts, Life Insurance (cash value), Stocks & Bonds, Home, Real Estate and other major assets.

| Type/Description | \$ Amount/Value |
|------------------|-----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| Total Assets: | _____ |

LIABILITIES:

Please list your liabilities including: mortgages, auto, personal, credit cards, and other obligations.

| Type/Description | \$ Amount/Value |
|--------------------|-----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| Total Liabilities: | _____ |



FINANCIAL INFORMATION

Who will be responsible for payment of your bills? Self _____ Other Person _____

Name and address of "other person": Name _____

Address _____ Phone _____

City: _____ State _____ Zip Code: _____

Relationship (e.g. Power of Attorney, Conservatorship): _____

Have you designated someone with Financial Power of Attorney to manage your affairs? Yes No

If yes, please describe type of power given (i.e., financial, durable, medical, general, limited, conservator, guardian) and list name, address, and phone number of person who holds such power. Please furnish a complete copy of the authorizing document, as well as any trust documents, wills and codicils which may pertain to these Powers.

Type of Power of Attorney: _____

Held by: Name _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

I certify that the information I have given in this Financial Information form is true and correct. I understand that any false statements or misrepresentations or omissions may result in the cancellation of my application or nullification of my Residency Agreement. I authorize Dirigo Pines Retirement Community to conduct a review of my financial status and obtain any information necessary to verify my ability to pay for my residency, including credit reports, etc. I further agree to give any other written comments required to confirm such information and to

