CONFIDENTIAL DATA APPLICATION

1 Johnsarbor Drive West ~ Rochester, NY 14620
Phone: 585-442-1300 Fax: 585-473-8856

The undersigned hereby applies for residency to The Hawthorne and agrees to comply with all current and future policies and procedures of The Hawthorne.

PERSONAL INFORMATION

Applicant's Name Last:		First:	
Address:			
City:	State:	Zip:	
Telephone Number:	Date of Birth:	Age:	Gender: _____Male_____Female

POWER OF ATTORNEY/GUARDIAN AND FAMILY INFORMATION

The following are the names, residences and phone numbers of any guardians, the holder(s) of my Power of Attorney and children. If no children, list interested relatives and friends. Note: Copy of POA is required prior to admissions if applicable.

1. Name:		Relationship:
Address: (include city, state, zip)		
Work Phone:	Home Phone:	Cell Phone:
2. Name:		Relationship:
Address: (include city, state, zip)		
Work Phone:	Home Phone:	Cell Phone:
3. Name:		Relationship:
Address: (include city, state, zip)		
Work Phone:	Home Phone:	Cell Phone:
4. Name:		Relationship:
Address: (include city, state, zip)		
Work Phone:	Home Phone:	Cell Phone:
5. *Power of Attorney Name:		
6. *Health Care Proxy Name:		
* **DNR**: ____*YES_____NO	* **MOLST**:_____*YES_____NO	* **If YES copy is required prior to admissions**

INSURANCE INFORMATION

Social Security Number	Medicare Number Including Letters	Medicaid Number
- -		

Medicare Part A Yes [ ] No [ ]		**Medicare Part B** Yes [ ] No [ ]	
Other Supplemental Insurance Yes [ ] No [ ]		**Policy Number**	**Group Number**
Long Term Care Policy Yes [ ] No [ ]		**Policy Number**	**Contact Phone Number** - -

If yes, please provide a copy of the long-term care policy for review of assisted living provisions and benefits.

PERSONAL FINANCIAL STATUS

MONTHLY INCOME

1. Social Security $_____
2. Pension/Retirement $_____
3. Interest Income $_____
4. Dividends $_____
5. Other Income: $_____

TOTAL INCOME $_____

LIABILITIES

1. Mortgages $_____
2. Home Equity Lines of Credit $_____
3. Reverse Mortgages $_____
4. Current Credit Card Debt $_____
5. Outstanding Medical Bills $_____
6. Personal Loans $_____
7. Other Liabilities $_____

TOTAL LIABILITIES $_____

ASSETS

1. Savings & CDs $_____
2. Stocks & Bonds $_____
3. Trust & Estate Equities $_____
4. *Value of Real Estate $_____
5. Address(es) of Real Estate

_____

6. Other Assets: $_____

TOTAL ASSETS $_____

*Is Real Estate owned by the applicant, available for sale, and will sale proceed be applied, if necessary, to fund residency at The Hawthorne? **YES**_____**NO**_____

MONTHLY EXPENSES

Hawthorne Monthly Rent for 2024	$ 7,134
Hawthorne Second Person Fee (if applicable)	$
Pharmacy	$
Out of Pocket Medical	$
Health Insurance Premium	$
Subscriptions	$
Life Insurance Premiums	$
Potential out of pocket home Health	$
Laundry & Dry Cleaning	$
Hair styling	$
Personal toilet & commissary goods	$
Medical/Recreational Transportation	$
Telephone Expense	$
OTHER:	$
TOTAL EXPENSES:	$

CERTIFICATION

I hereby declare that all statements made on this application are true and accurate to the best of my knowledge. I understand that failure to provide accurate and truthful information may result in termination of this agreement and my residence at St. John's Meadows at any time. I have not withheld any information requested herein, and have read this application or had it read to me and it has been fully explained to me.

All prospective residents will complete a health and financial review to determine eligibility for residency at The Hawthorne. The decision to accept applicant for residency is at the sole discretion of sponsor. Such decisions will be consistent with applicable non-discrimination and civil rights laws.

Signature of Applicant Date

Witness Date

THE HAWTHORNE
AT ST. JOHN'S MEADOWS

IN COMPLIANCE WITH ALL FEDERAL AND STATE CIVIL RIGHTS LAWS AND REGULATIONS, THE HAWTHORNE DOES NOT DISCRIMINATE BASED ON RACE, CREED, COLOR, DISABILITY, NATIONAL ORIGIN, SEXUAL ORIENTATION, MILITARY STATUS, AGE, SEX, MARITAL STATUS OR FAMILIAL STATUS IN THE APPLICATION FOR RESIDENCY, RETENTION AND CARE UPON RESIDENCY. THE HAWTHORNE TREATS ALL PROSPECTIVE RESIDENTS AND RESIDENTS ON THIS NON-DISCRIMINATORY BASIS.

*The Hawthorne is a non-smoking community.

St John's HAWTHORNE

CONFIDENTIAL HEALTH STATUS REPORT

HEALTH INFORMATION

Applicants Name _____ _____
Last Name First Name M.I.

1. Summary of Significant Medical Conditions, if any:

2. Current Listing of Medications:

3. Known Allergies: (medications, food, environmental)

4. Please briefly describe the assistance required.

5. Please list and briefly describe the reasons for any periods of hospitalization, surgeries, or psychiatric illness, you have had in the past three years.

6. Please provide the name, address and telephone number of your **primary care physician.**

Primary Care Physician Name:
Address:
Phone:

7. Please list the names of any other physicians or health professionals you have seen in the last 12 months, and indicate their areas of specialty.

Physician Name:	Area of Specialty:
Address:	
Phone:	

Physician Name:	Area of Specialty:
Address:	
Phone:	

Physician Name:	Area of Specialty:
Address:	
Phone:	

Physician Name:	Area of Specialty:
Address:	
Phone:	

I acknowledge that acceptance of my application for occupancy of a residence at The Hawthorne will be determined by The Hawthorne based on the information I provide to sponsor. I further understand that, prior to approving my application for residency at The Hawthorne at St. John's Meadows, a written statement of health condition (form 3122) must be completed by a primary care physician and that the sponsor may request additional information concerning my health status. I hereby declare that all statements made herein and all other information I have provided to Sponsor in connection with my application for residency are true according to my best knowledge and belief.

_____ _____

Signature Date