THE LANDINGS
AT REED STATION CROSSING

ADMISSION PROCESS CHECKLIST

The documents listed below and / or attached are to be completed and returned prior to residents' official move-in.

◯ **COMPLETE & RETURN APPLICATION FOR RESIDENCY & FINANCIAL DISCLOSURE FORM**

◯ **PLACE DEPOSIT ON ROOM & COMPLETE RESERVATION AGREEMENT (if needed)**

◯ **SIGN & RETURN AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

- One of the most important steps to this process is obtaining the physician's orders from the potential residents' primary physician to ensure that we have an updated medical history and medication list for potential resident.
- This form gives The Landings the authorization to contact the physician and will need to be signed and returned prior to obtaining medical documents.

◯ **SIGN & RETURN PUBLIC PHOTO& PUBLICITY RELEASE FORM**

◯ **SCHEDULE & COMPLETE NURSING ASSESSMENT**

- Nursing Assessments are typically completed Monday-Fridays 8-2pm with our Director of Nursing.
- Our administrative staff will be in touch to coordinate the official date & time of the nursing assessment.

THE LANDINGS
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ADMISSION PROCESS CHECKLIST CONT.

The documents listed below and / or attached are to be completed and returned prior to residents' official move-in.

ITEMS NEEDED AT THE TIME OF NURSING ASSESSMENT

- Drivers License
- SS Card
- Insurance Cards
- Medication List including supplements & vitamins
- Vaccination Records (flu, pneumonia)
- COVID Vaccination (if vaccinated)
- DNR Paperwork
- Power of Attorney Paperwork
- Living Will
- Advanced Directives

○ **CONTRACT SIGNING & RESIDENT ORIENTATION**

- Contract Signing & New Resident Orientation must be completed Monday-Friday between 8am-12pm with Administrator, prior to move-in.

○ **SCHEDULE MOVE-IN DAY!**

- We recommend that move-ins are done Monday- Friday between 8am-3pm to ensure our administrative & maintenance staff are here to help assist you through the process.
- Carts and dollies available upon request.
- Additional move-in information can be provided upon request.

If you have any questions, please do not hesitate to ask! We are happy to help!

THE LANDINGS
AT REED STATION CROSSING

APPLICATION FOR RESIDENCY

Resident Information:

Today's Date: _____ Move-In Date: _____
Move-Out Date (if applies): _____
Resident's Full Name: _____ DOB: _____
Phone: _____ Present Address: _____
City, State, Zip:
_____
Social Security Number: _____ Are you your own decision maker? ___Yes or ___No
Co-Applicant Full Name: _____ DOB: _____
Social Security Number: _____ Are you your own decision maker? ___Yes or ___No

Primary Contact Information:

Name: _____ Relationship: _____ Phone: _____ Alt Phone: _____
Address: _____
City, State, Zip:
_____
Is the above contact designated as Power or Attorney or Guardian? ___Yes or ___No
Does the above contact have rights to view your records? ___Yes or ___No

Secondary Contact Information:

Name: _____ Relationship: _____
Phone: _____ Alt Phone: _____
Address: _____
City, State, Zip:
_____
Is the above contact designated as Power or Attorney or Guardian? ___Yes or ___No
Does the above contact have rights to view your records? ___Yes or ___No

Authorization for release of information:

I/we hereby authorize The Landings at Reed Station Crossing to conduct a criminal background check and in case of medical emergency, (ambulance, hospital services, etc), I authorize The Landings at Reed Station Crossing to release medical information to outside medical services.

_____ _____
Resident or POA (if applicable) Signature **Date**

_____ _____
Co-Applicant or POA (if applicable) Signature **Date**

THE LANDINGS
AT REED STATION CROSSING

APPLICATION FOR RESIDENCY

Additional Information:

Are you a Veteran? ___Yes or ___No
Co-Applicant: Are you a Veteran? ___Yes or ___No

If yes, do you use VA services? ___Yes or ___No
Co-Applicant: ___Yes or ___

Do you use durable medical equipment (DME)? Ex: walker, cane, oxygen, raised toilet seat, wheelchair, etc.? If yes, list here _____
Co-Applicant: _____

Do you use a wheelchair, are you able to transfer in and out of wheelchair without assistance?
___Yes or ___No
Co-Applicant: ___Yes or ___

Do you use dentures, hearing aids, or glasses?
If yes, list here _____ Co-Applicant:
___Yes or ___

Physician Information:

Primary Care Physician: _____ Phone: _____
Fax #: _____
Primary Pharmacy: _____ Phone: _____

_____ _____

Resident or POA (if applicable) Signature **Date**

_____ _____

Co-Applicant **Date**

THE LANDINGS
AT REED STATION CROSSING

PHOTO & PUBLICITY RELEASE FORM

PHOTO RELEASE

I, _____, give the The Landings at Reed Station permission to use my name, likeness, image, voice, and/or appearance as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken or made on behalf of The Landings at Reed Station Crossing activities. I agree that The Landings at Reed Station Crossing have complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with The Landings missions. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc for the use of such pictures, etc., and hereby release The Landings and its agents and assigns from all claims which arise out of or are in any way connected with such use.

- I have read and understood this consent and release ____
- I give my consent to The Landings at Reed Station Crossing to use my name and likeness to promote The Landings program and their activities ____
- I do not give my consent to The Landings at Reed Station Crossing to use my name and likeness to promote The Landings program and their activities ____

PHONE NUMBER RELEASE

- I give my consent to The Landings at Reed Station Crossing to contact my cell phone number for activity reminders ____
- I do not give my consent to The Landings at Reed Station Crossing to contact my cell phone number for activity reminders ____

_____ **Printed Name of Applicant**

_____ **Printed Name of Co-Applicant**

_____ **Signature of resident or POA if applicable**

_____ **Signature of Co-applicant**

THE LANDINGS
AT REED STATION CROSSING

RESERVATION AGREEMENT

The Landings of Carbondale, LLC, a senior living community located at 2100 Reed Station Parkway, Carbondale, IL62901, acknowledges receipt of a reservation fee in the amount of _____ DOLLARS ($_____) for Apartment Number ____ or the first available _____ Apartment in The Landings (the "Apartment") from _____ (collectively, if more than one, "Prospective Resident").

Select One:

◯ **The monthly fee for one person in the the apartment and all standard services is $ _____per month.**

◯ **There will be two (2) persons living in the apartment. The additional fee for a second person will be $ _____ per month, for a total monthly fee for two persons of $_____ per month.**

The Reservation Fee is refundable upon request in the event the Prospective Resident wishes to cancel this reservation within 72 hours of signing the Reservation Agreement for the Apartment. Upon check in the Reservation Fee will be applied to the first month's rental fee.

The following are basic requirements for Independent Living residency in The Landings:
1.Residents must be 55 years of age or older.
2.Residents must be able to live independently.

In order to comply with this criteria, a health care provider's health assessment may be required confirming that the Resident would be able to live independently. If a health assessment is required, an approved Independent Living Health Assessment form must be utilized to fulfill this requirement. This information must be received by The Landings staff prior to confirming a move-in date.

The Landings is a smoke-free community. Other guidelines, rules and residency requirements for The Landings are listed in the Resident Admission Agreement and the Resident Handbook.

_____	_____	_____
Print Name of Resident or POA if applicable	**Signature of Resident or POA if applicable**	**Date**

Accepted By: The Landings at Reed Station Crossing

_____	_____
Signature	**Date**

THE LANDINGS
AT REED STATION CROSSING

FINANCIAL APPLICATION & FINANCIAL DISCLOSURE

Notice of Intent: The purpose of this form is to ensure applicants for residency meet the medical criteria for independent living and have adequate resources to cover the monthly rental fee, plus average personal expenses. This is not intended to be a full and complete disclosure of your financial standing. As such, you may not need to answer all questions to demonstrate financial eligibility. If concerns regarding financial or medical eligibility arise, you may be asked to furnish more detailed information.

Pledge of Confidentiality: We understand the sensitivity of the information required to base a decision of financial and medical eligibility for residency at The Landings. Please be assured all information you provide is used solely for the purpose of determining eligibility for residence and is kept in the strictest confidence. Should you decide not to pursue residency, any and all application materials containing your confidential information will be returned upon your request.

Instructions: Please fill in the blanks or check the appropriate responses. (If the question does not apply or does not require financial disclosure, please indicate N/A in the blank provided.) Please complete the entire application. Incomplete applications will cause delays in processing your request for residency.

Identifying Information:

Name: _____ DOB: _____ Phone: _____

Street Address: _____

City, State, Zip:

_____ Social Security Number: _____

Preferred Title: ___Mr ___Mrs ___Miss ___Other: _____

Current Residence:

How long have you lived at your present address? _____

Do you own or rent your current home? ___Own ___Rent

What is the amount of your monthly rental or mortgage? _____

If you are a homeowner:

Do you plan to sell your home before moving to The Landings? ___Yes ___No

THE LANDINGS
AT REED STATION CROSSING

FINANCIAL APPLICATION & FINANCIAL DISCLOSURE

Please indicate the appropiate range for the asssessed value of your home:

___ $75 or less ___ $75 - $100,000 ___ $100 - $150,000 ___$150 or more

Financial Disclosure:

- Income: Please indicate the appropriate range for your total annual income. (Sources of income include social security and pension benefits, as well as rental income, interests, etc.

___ $15 - $20,000 ___ $20 - $25,000 ___$25 - $30,000 ___ $35 - $45,000 ___$45 - $50,000 ___$75 - 100,000

- Assets: Please indicate the appropriate range for the total value of your assets. (Assets include savings and investments, such as CD's, stocks, bonds, mutual funds, insurance, annuities, etc.)

___ $10 - $20,000 ___ $20 - $30,000 ___$30 - $40,000
___ $40 - $45,000 ___$50 - $75,000 ___$75 - 100,000
___ $100 - $150,000 ___$150 - $200,000 ___$200,000 or more

Real Estate:

Do you own property in addition to your current home? ___Yes ___No ___N/A
If yes, please indicate the appropriate range for the assessed value of your other real estate holdings:

___ $50,000 or less ___ $50 - $75,000 ___$75 - $100,000 ___ $100 - $150,000 ___$150,000 or more

THE LANDINGS
AT REED STATION CROSSING

FINANCIAL APPLICATION & FINANCIAL DISCLOSURE

Financial Affairs:

Will you be handling your own affairs? ____Yes ____No

Have you established a financial Power of Attorney (POA) or Living Trust? ____Yes ____No

If yes, please provide the following information:

Name of Power of Attorney or Trust Administrator:_____

Phone:_____ Address:_____

Email Address:_____ Relationship to Applicant:_____

If your monthly invoices should be sent to someone other than yourself, please provide the following identifying information for that individual:

Name:_____ Phone:_____

Address: _____

Email Address:_____

Are you planning to maintain an automobile while a resident of The Landings? ____Yes ____No

Sources of Current Monthly Income (record actual amount)

	Applicant	**Spouse**
Social Security:	_____	_____
Veterans Pension:	_____	_____
Other Pension Number:	_____	_____
Dividends:	_____	_____
Interest:	_____	_____
IRA/TDA/TSA:	_____	_____
Other Income (list sources)	_____	_____
Total Monthly Income:	_____	_____

THE LANDINGS
AT REED STATION CROSSING

FINANCIAL APPLICATION & FINANCIAL DISCLOSURE

Sources of Cash Assets (record actual amount)

	Applicant	Spouse
Savings:	_____	_____
Checking:	_____	_____
CDs:	_____	_____
Maturity Date:	_____	_____
Stocks & Bonds:	_____	_____
IRA/Annuities:	_____	_____
Life Insurance:	_____	_____
Life Insurance:	_____	_____

Total Cash Assets: _____ _____

Financial Disclosure Statement: (Must be completed by each individual: joint holdings must be noted)

____ I certify that the information contained in this application is true and correct to the best of my knowledge. I understand that any misrepresentation of the information contained in this application may disqualify me from residency at The Landings.

____ I am aware that The Landings is not a health care facility, and I am independent with respect to daily living. Furthermore, I recognize I may be asked to provide a medical doctor's written certificate regarding my ability to live independently after my application has been conditionally approved.

_____ _____

Signature of Resident or POA if applicable **Date**

_____ _____

Signature of Co-Applicant **Date**

THE LANDINGS
AT REED STATION CROSSING

AUTHORIZATION FO R USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health care provider _____ (insert name) disclose my health information during the term of this authorization to the recipient(s) that I have identified below.

Recipient(s): I authorize my health care information to be released to the following recipient(s):

Name: The Landings at Reed Station Crossing

Address: 2100 Reed Station Parkway Carbondale IL 62901

_____

Purpose: I authorize the release of my health information for the following specific purpose: **to provide continuum of health care.**

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All my health information that my provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ Only the following records or types of health information:

_____

Term: I understand that this authorization will remain in effect:

- From the date of this authorization until the ____ day of _____, 20___.
- Until the provider fulfills this request.
- Until the following even occurs: my discharge from The Landings

_____ _____ _____

Name of Applicant Signature Date _____ _____

_____

Name of Co-Applicant Signature Date

If individual is unable to sign this authorization, please complete the information below:

_____ _____ _____

Name of Guardian/Representative Legal Relationship Date

_____

Witness