# Barton Woods Assisted Living Admission/Waitlist Information

**Application & Deposit Process**:

- Fill out the Application & Waitlist Agreement, Authorization to Release Medical Information, Authorization to Obtain Medical Records, and Resident Representative Form
- Payment of a $1500.00 deposit and application fee per resident ($1200.00 deposit + $300.00 application fee). The $1500.00 deposit & application fee is refundable if your loved one doesn't move into Barton Woods. The refund will be processed within 30 days of refund request. If the move-in process has begun, the $300.00 application fee is not refundable. If the move-in process and apartment preparation has begun the $1500.00 deposit & application fee is not refundable.

**Waitlist Process**: *Please disregard if an apartment is immediately available.*

- Your name is entered chronologically onto the Waitlist by the date you join. You can place your name on the list for more than one style of assisted living suite/apartment.
- When a suite/apartment becomes available, the first person on the list will be contacted & offered that accommodation.
- There are three opportunities to turn down an accommodation before being placed at the bottom of the waitlist.

Please carefully read the Assisted Living Application and Waitlist Agreement. If you have any questions or concerns, please contact Barton Woods Assisted Living administration.

Rebecca Williams, Facility Director – (989) 695-5380 ext. 111 rwilliams@bartonwoods.org
Kelsey Treichel, Resident Care Director – (989) 695-5380 ext. 107 ktreichel@bartonwoods.org

# Barton Woods Waitlist Agreement

(I) (We) hereby make application for the Waitlist at Barton Woods Assisted Living.

(I) (We) prefer the following Apartment Type(s):

Choice 1: _____ Choice 2: _____

This application is submitted with a refundable Waitlist deposit of $1250.00. The deposit is per person. When notified of an appropriate apartment (I) (We) intend, to pay the balance of the Community Fee or Community Fee deposit, whichever is appropriate, minus the refundable deposit paid, and execute a Resident Care Agreement. Please indicate title: (Mr., Mrs., Miss, Ms.)

| | |
|---|---|
| _____ | _____ |
| Applicant Name | 2nd Applicant Name |
| _____ | _____ |
| Street Address | Street Address |
| _____ | _____ |
| City, State, Zip Code | City, State, Zip Code |
| _____ | _____ |
| (Area Code) Telephone | (Area Code) Telephone |
| _____ | _____ |
| Date of Birth | Date of Birth |
| _____ | _____ |
| Social Security Number | Social Security Number |
| _____ | _____ |
| Email | Email |
| _____ | _____ |
| Phone Number | Phone Number |

(I) (We) understand that submitting this application will place (my) (our) name (s) on the Barton Woods Assisted Living Waitlist in chronological order. (I) (We) further accept the terms of the Waitlist Agreement shown on the next page.

Applicant's Signature _____ Date _____

2nd Applicant's Signature _____ Date _____

# Barton Woods Waitlist Agreement

1. In return for the payment of the refundable Waitlist deposit, and submitting a completed Confidential Data Application, applicants will be considered for admission in the order of their position on the list.

2. The application does not entitle applicants to admission to Barton Woods Assisted Living, but only to priority consideration for admission. The decision to admit or not to admit an applicant is made by Barton Woods Assisted Living in the exercise of its sole discretion. The applicant agrees to accept such decision as binding and final in all respects.

3. Barton Woods will credit an applicant's Waitlist deposit against the Community Fee upon execution of the Residence and Care Agreement.

4. An applicant's rights under this agreement are personal to him or her, may not be assigned and shall not pass to his or her heirs or personal representatives. If application is made by two persons together, both are deemed to be included in the word "applicant" as used in this agreement.

5. Any notice to an applicant shall be sufficient if mailed to the address given or as applicant later advises Barton Woods.

6. By signing this agreement now and submitting a Confidential Data Application (I) (We) agree to submit the balance of Deposit & Application Fee and sign the Resident Care Agreement within seven days of notification.

Initial: _____ Date: _____

7. This Waitlist Agreement shall terminate if any one of the following occurs:
    a. The Applicant's application for admission is rejected by Barton Woods.
    b. Barton Woods receives written notice of termination and a refund request. This process could take up to 60 days.
    c. The applicant executes a Resident Care Agreement and pays Deposit & Application Fee, in which event all rights and obligations of the parties shall be governed by the Residence and Care Agreement.
    d. The applicant fails to deliver a signed Resident Care Agreement and the Deposit & Application Fee within seven days of notification.

8. Within thirty days after receipt of the Deposit and Application Fee and the signed Resident Care Agreement, the Cost of Care will begin and be due.

Initial: _____ Date: _____

# Authorization to Release Medical Information

Medical Practice/Physician: _____

Patient's Name: _____

Address: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

I, _____, understand that my medical record contains confidential information. If I have discussed certain sensitive information with my personal physician or other provider, my medical record may also make reference to this information. Sensitive information includes alleged or actual drug/substance abuse; testing/treatment for AIDS or HIV; or treatment of psychiatric conditions. The above named medical practice has kept the information in my medical record in strict confidence. This information is being released at my request. I also understand that the above-named medical practice and/or physician cannot be held responsible for how this information is used once it is released.

I hereby authorize release of my medical information to:

Barton Woods Assisted Living
9472 Kochville Road
Freeland, Michigan 48623

_____ _____

Date Resident or Representative Signature

# Authorization to Obtain Medical Records

I authorize _____ to release to Barton Woods Assisted Living ("Provider") such medical records and related information as Provider requests, for the purpose of providing medical care and treatment, concerning:

_____ _____

Resident/Patient Birthdate

Any restriction that I wish to impose on this authorization is listed below:

_____

_____

I understand that Provider will not refuse to provide care to me if I refuse to sign this Authorization.

I have the right to so refuse.

I understand that I have the right to revoke this authorization.

_____ Name of Resident (Printed)

_____ _____

Signature of Resident (or legal responsible individual) Date

_____ _____

Witness Date

# Resident Representative Form

## Information on Potential Resident's Representative

Name: _____

Address: _____

City: _____ State: _____

Phone: _____ _____
Cell Home

Relationship to Potential Resident: _____

Signature: _____ Date: _____

Comments: _____

_____

_____

_____

# Application for Assisted Living

Name: _____ Target Move-In Date: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Date of Birth: _____

Cell Phone Number: _____ Email: _____

Physicians Name: _____ Telephone Number: _____

If Resident has executed a Power of Attorney or if a Guardian has been appointed for a Resident, copies of Power of Attorney or Guardianship Decrees must be provided to Provider PRIOR to admission of the Resident, and copies of Advanced Directives and DNR/MOLST forms prior to or at admission.

Power of Attorney: Financial __ No __ Yes Whom: _____ Phone: _____
Healthcare __ No __ Yes Whom: _____ Phone: _____

Advanced Directives: __ No __ Yes DNR/MOLST Form: __ No __ Yes

Guardianship: __ No __ Yes Whom: _____ Phone: _____

Any arrangement (financial, religious, name of preferred funeral director, if any) the resident has made, or wished to make with regard to burial.

Name: _____ Phone: _____

Address: _____

Relationship of person who agrees to assume custody of the resident should resident pass away and assume funeral or burial responsibility.

Name: _____ Phone: _____

Address: _____

In Case of Emergency Contact #1:

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
City/State/Zip: _____ Cell Phone: _____
Email: _____

In Case of Emergency Contact #2:

Name: _____ Relationship: _____
Address: _____ Home Phone: _____
City/State/Zip: _____ Cell Phone: _____
Email: _____

List all Medical Diagnosis:

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List Current Medications: (Please attach copy of current medication list complete with medication name, dosage, frequency and route i.e. oral, topical and prescribing physician name and telephone number)

List Any Allergies: _____

List Dietary Concerns: _____

Appetite: Good _____ Fair _____ Poor _____

Favorite Food/Desserts: _____

Any Specific Behaviors or Cues to Define a Personal Need? _____

| Functional Status: | Self | Assist | Total | Specify |
|---|---|---|---|---|
| Feeding | | | | |
| Bathing | | | | |
| Toileting | | | | |
| Oral Care | | | | |
| Walking | | | | |

Elimination:

| | | | |
|---|---|---|---|
| Bladder | Continent _____ | Incontinent _____ | Special Cueing _____ |
| Bowel | Continent _____ | Incontinent _____ | Special Cueing _____ |

Communication Deficits: Hearing _____ Vision _____ Speech _____ Language _____

Prosthesis: Glasses _____ Contacts _____ Hearing Aid _____ Dentures _____ Limb _____

Family History:
Where was individual born? _____

Where did they grow up? _____

Education: _____
Work History: _____

Marital Status: Single _____ Married _____ Widow _____ Other _____

Resident Hobbies (Past or Present):
Physical Activities _____ Games _____ Crafts _____ Art _____ Spiritual _____ Intellectual _____
Sports _____ Social/Cultural _____ Music _____ Other _____

Resident Likes: _____

Resident Dislikes: _____

If the resident is coming from out of town, who would be a contact person that has been close to he/she?

Name _____ Relationship _____

Phone _____ Email _____

Resident or the Resident's legally authorized representative hereby authorizes healthcare providers to release to Administration at Barton Woods any and all health care information requested by resident making application. This authorization shall be in effect for one (1) calendar year from the date that appears below. In addition, Resident or Resident's legally authorized representative hereby consents to independent evaluation of Resident by any provider designated by Barton Woods at its sole discretion at Resident's and Guarantor(s)' sole expenses.

Signature: _____ Date: _____