Application

Applicant Name(s) ______________________ Date: ____________

Street: ______________________ City: ____________

State: ________ Zip: ________ Home # ____________ Work # ____________

Applying for (S)ingle or (C)ouple: ______ Move In Date Desired: ______ Apartment Type Desired: ______

(S)ingle (M)arried (D)ivorced (W)idowed: ______ Date of Birth: ________ Social Security #: ________

Spouse Information

Name: ______________________ Social Security #: ____________

Military ID Card #: ____________ Expiration Date: ________ Date Of Birth: ________

Date Of Marriage: ____________ Place of Marriage: ____________

If applicant is an officer, fill in this section:

Branch of Service: ____________ Years of Service: ____________

Rank: ____________ Date of Commission: ____________

Source of Commission: ____________ Date Retired: ____________

Military Privileges: Yes / No

If applicant is not an officer, fill in the sponsor information below:

Name: ____________ Relationship: ____________

Street Address: ______________________

____

City: ____________ State: ________ Zip: ________

Phone Number: ____________ Rank: ________ Years of Service: ______

Branch of Service: ____________ Source of Commission: ____________

Soc Sec # / Service #: ____________ Date of Commission: ____________

Sponsor Date Retired: ____________ Date Deceased: ____________

Medicare / Medicaid Information:

Medicare# Including Letter: ______________________

Medicare Part A: Yes / No Medicare Part B: Yes / No

Medicare Start Date: ____________ Spouse's Medicare # Including Letter: ____________

Medicaid: Yes / No If yes, Number: ____________ Medicaid Start Date: ____________

Tricare Eligible: Yes / No Spouse's Tricare Eligible: Yes / No

Insurance Information:

Health Insurance Co.: Husband or Wife: Policy Number: Type of Policy:

____

____

____

____

Long Term Care Insurance Co.:

____

I agree that when I become a resident of Knollwood, I will, if eligible, enroll in, or remain enrolled in, Medicare and the medical insurance part of Medicare; or provide my own private insurance coverage which, in the judgment of The Army Distaff Foundation, Inc., will provide substantially equivalent benefits.

Will / Power of Attorney

General Power of Attorney Name: ____________________ Phone: ____________

Will: Yes / No Executor/Executrix Name: ______________________________

Executor Address: ______________________________

____

____

City: ____________________ State: __________ Zip: __________

Executor Phone #: ______________________________

State where executed: ______________________________

Advance Directives: Yes / No

Durable Power of Attorney for Medical: Yes / No

Living Will: Yes / No

Primary Contact:

Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone: ____________________ Work Phone: ____________________

Relationship: ______________________________

Notes: ______________________________

____

____

I do ____ do not _____ have sufficient financial resources to pay my admission fee and monthly service charge.

Financial Profile:

Monthly Income

- Social Security $ ____________________
- Retirement/Pension (source) $ ____________________
- Rental Income $ ____________________

Residence (If resident owns–sole or joint ownership)

Value (approximate) $ ____________________

Mortgage (approximate) $ ____________________

Assets (Current balance of)

Saving Account(s)	$ ______________
Checking Account(s)	$ ______________
Stocks	$ ______________
Bonds	$ ______________
Certificates of Deposit	$ ______________
Real Estate	$ ______________
Other (describe)	$ ______________

Liabilities (Medical bills, credit cards, charge accounts, loans)

Dollar Total	$ ______________
Specify Liabilities	$ ______________

I hereby attest that the above financial information is accurate and assets are available to the resident to pay for services received at Army Distaff Foundation. It is understood that Army Distaff Foundation relies on the accuracy and completeness of the information furnished in order to make an admission decision.

______________________________ ______________

Responsible Party's Signature Date

I hereby authorize any organization, person or governmental agency having knowledge of my affairs to disclose to The Army Distaff Foundation, Inc., its officers or representatives, any and all information concerning physical, business, property or financial condition. And, if my financial situation requires it, I authorize the Foundation to explore with my near relatives the assistance, if any, which they may be able to give me. I understand that information contained herein or acquired as a result hereof pertaining to my physical condition and my financial and business affairs will be treated as confidential by the Foundation.

Submitted herewith is my application deposit in the form of a check or money order, for $1,500, payable to The Army Distaff Foundation, Inc. If my application to Knollwood is accepted, this deposit will be applied toward my Admission Fee. If my application is not accepted, my deposit will be returned. The application deposit will not be returned after a contract has been signed.

Upon acceptance of this application, and my signing a contract, I understand that an initial contract payment of $3,500 must be paid. The $3,500 amount paid will be applied towards the total admission fee, and will only be refunded in the event of withdrawal, or death. Once the $3,500 and a signed contract are received by the Foundation, I will then be placed on the future waiting list. This establishes my precedence for the type of apartment I have selected.

I understand that at the time of residency in Knollwood, I must fully pay the remainder of the total admission fee for the apartment type that I have selected, and that there will be an additional monthly service charge.

Signature of Applicant(s) ______________________________ Date ______________

Signature of Witness ______________________________ Date ______________

PLEASE ATTACH A COPY OF RETIREMENT ORDERS OR DD FORM 214

6200 Oregon Avenue, N.W., Washington, D.C. 20015

PRELIMINARY MEDICAL REPORT

(to be filled in by applicant)

Name: ____________________

Address: ____________________

____

Age: __________ Telephone Number: __________ Color of Eyes: __________ Color of Hair: __________

Personal Physician: ____________________

Address: ____________________

____

1. What serious adult diseases have you had? ____________________

____

____

2. Do you, at this time, have either an acute or chronic ailment? ____________________

   If YES, give details. ____________________

____

3. Are you on any medication? ____________________

   If YES, please specify. ____________________

____

3b. Any known medication allergies? ____________________

   If YES, please specify. ____________________

____

4. Are you able to walk, feed and clothe yourself without assistance? ____________________

   If NO, please specify assistance needed. ____________________

____

____

4b. Do you at this time have any outside help coming into your home? ____________________

   If YES, please specify. ____________________

____

____

5. State all previous surgery with approximate dates. ____________________

____

____

6. Has your doctor imposed any treatment restrictions? ____________________

____

7. Have you ever used alcohol or habit-forming drugs to excess which required medical treatment? __________

____

This application shall be used to determine initial eligibility to enter Knollwood, and a MORE COMPLETE MEDICAL REPORT MUST BE SUBMITTED prior to residence.

Applicant's Signature ____________________ Date __________