When submitting your completed Application:

☑ FOR ALL RESIDENTS:

☐ Please make sure all sections are filled out completely.
☐ Make sure you sign and date all paperwork
☐ Include the application fee of $150.00 made payable to TRH.
☐ Signed Agreement from the Resident Handbook

❏ INDEPENDENT RESIDENT:

☐ Application
☐ Resident Authorization
☐ Copy of Advanced Directive
☐ Copy of Durable Power of Attorney

❏ RCF RESIDENTS:

☐ Application
☐ Resident Authorization
☐ Medical Application
☐ Copy of Advanced Directive
☐ Copy of Durable Power of Attorney
☐ POLST Form

Providing a Caring Community for Christians in Retirement

5405 Boise St. SE ~ PO Box 970, Turner, OR 97392 503-743-2490

Application Form

I present the following information to Turner Retirement Homes with the understanding that the facts contained herein will be held in strict confidence to be used only by the administrative and admissions personnel.

Today's Date: ___________________________ Marital Status: ☐Single ☐Married

Name:____ Phone: ________________________________

Name of Spouse: ____ Phone: ________________________________

Address:____ Email: ________________________________
City State Zip

Type of unit desired: (Check appropriate box or boxes) Projected date of coming: __________________________

1. Independent Living: ☐ Apartment (one or two bedroom) ☐ Gracious Living (one bedroom apt.)

☐ Cottage (one or two bedroom) ☐ Duplex (one or two bedroom) ☐ Two bedroom house

2. Licensed Residential Care: ☐ Octaplex (studio-like apartment) 3. Life Lease: ☐

How did you learn about our facilities? ____

Do you have friends or relatives living at Turner Retirement Homes? ☐ Yes ☐ No

Name/Location: ____ Relationship: ______________________________

Name/Location: ____ Relationship: ______________________________

Personal Information

Date of Birth: Month___________________________Day:___________Year:_____________Current Age:_____________

Place of Birth: City_____________________________County:____________________________State:_________________

Spouse's Date of Birth: Month____________________Day:___________Year:_____________Current Age:_____________

Spouse's Place of Birth: City: ________________________County: ___________________State: ____________________

Wedding Anniversary:_____________________________

Member of what church? _______________________________________ How long? ________________________________

Minister's name: _______________________________ Date of immersion: self _______________spouse _______________

Will you have an automobile on the premises? ☐Yes ☐No If yes then fill out the following:

Automobile: Make Model Year License No. State Owner

____

Who to Contact in Case of an Emergency

Your nearest living relatives/responsible parties (in order of emergency notice)

1. Name:________________________ Address:____ zip code

Relationship: ________________ Phone:(H)____________ (W)____________ (C)____________

2. Name:________________________ Address:____ zip code

Relationship: ________________ Phone:(H)____________ (W)____________ (C)____________

3. Name:________________________ Address:____ zip code

Relationship: ________________ Phone:(H)____________ (W)____________ (C)____________

References: Please provide us with three

1. Name:___________________________ City/State____________________ Phone #____________

2. Name:___________________________ City/State____________________ Phone #____________

3. Name:___________________________ City/State____________________ Phone #____________

Medical and Insurance Information

Hospitalization Medical Insurance:

Company:_______________________________ Policy #_____________________________

Group:_________________________________ Monthly Premium $ ____________________

Nursing Home Insurance:

Company:_______________________________ Policy #_____________________________

Group:_________________________________ Monthly Premium $ ____________________

Responsible Party

If you should become unable to care for your affairs, who should be contacted to act on your behalf and to manage your estate?

Name: ______________________________________Relationship: ____

Address: ___________________________City:______________State:________Zip:________Phone:______________

Guardianship: ☐ Yes ☐No   Power of Attorney: ☐Yes ☐No   Durable POA for health care: ☐ Yes ☐No

Do you have a Living Will? ☐Yes ☐No   If yes, is family aware? ☐Yes ☐No

Please Read and Sign before Sending in this Application

I/We present this information to Turner Retirement Homes and give TRH permission to contact my references and understand that this application is only the preliminary step in the resident selection process and in no way guarantees me occupancy. I also acknowledge that TRH is a Non-Smoking and Non-Alcohol facility, and will agree to abide by TRH rules and policies as indicated in the Resident Handbook.

____ Date _____________________________________
Signature of Applicant

____ Date _____________________________________
Signature of Applicant

The following must be sent in along with application:

☐ $150 non-refundable Application Fee   Date Paid____________________Check # ____________________

☐ Copy of Advanced Directive

☐ Copy of Durable Power of Attorney

Independent Residents Only: One small pet is allowed with refundable pet deposit of $750.00.

For Office Use Only

Recommendation: ☐ Approved ☐ Pending

____

____

____

Signature: ____ Date: ________________________
Admissions Chair

Final Instructions

(This is not required but encouraged)

Final instruction for: ____

If I should pass away while I am a resident member of Turner Retirement Homes, please observe the following instructions and notify the following:

Name	Address	Phone	Relationship

Mortuary name: ____

Address: ____ Phone: _________________________

Is service prepaid? ☐ Yes ☐ No If yes, please explain: ___________________________

____

Cemetery name: ____

Address: ____

Is space purchased? ☐ Yes ☐ No If yes, please give description and location _________

____

Miscellaneous wishes or special instructions: (minister, pallbearers, singer, scripture, military honors, etc.)

____

____

____

Signature: ____ Date: ____________________________

Resident Authorizations

This is a three (3) part form. Section 1 is for All residents; Section 2 has additional questions for RCF residents. All residents should complete section 3.

I,_______________________________ authorize the staff of Turner Retirement Homes to do the following: (mark yes or no).

Section I – All Residents

☐Yes	☐No	I understand that photos and videos are sometimes taken to record activities and special events and that these pictures may be used within this community or in news stories about the community. You have my permission to include my picture.
☐Yes	☐No	Staff may enter my apartment in my absence in order to deliver services, check on well-being, to do maintenance & routine safety checks, or to perform other tasks at my request. Additional instructions:
☐Yes	☐No	Provide other residents in the facility with discreet, general information about my will-being if they inquire, without revealing extensive details of my condition. Additional instructions:
☐Yes	☐No	Receive, hold and deliver as appropriate supplies, equipment, medication, mail or other items which I order and request to have delivered. Additional instructions:
☐Yes	☐No	Send my monthly bill to the person designated the Responsible Party on my Resident Application or to the person who has agreed to act as my Power of Attorney. Additional instructions:

Independent residents can skip down to Section 3 at the bottom of the second page. Continue to Section 2 if you are a resident in the Residential Care Facility.

Section 2 – Residential Care Facility Residents Only

☐ Yes	☐ No	Invite my family/primary contact to participate in my service planning meetings. Additional instructions:
☐ Yes	☐ No	Discuss my service needs or preferences and Service Plan issues with my family or significant others known to the staff at Turner Retirement Homes. List any specific restrictions or additional instructions:

Section 2 – RCF Only Continued

☐ Yes	☐ No	Discuss my needs and services with my doctor and other appropriate health care providers. Additional instructions:
☐ Yes	☐ No	Accept the signature of the following on my behalf on agreements, amendments to agreements of my Service Plan if I am unable to sign. This is someone I trust to understand my wishes and to act based on those wishes. Identify any other persons and any additional instructions:
  ☐ ☐ ☐	 Dn Rm Apt Office	If staff are administering my medications, please deliver these to me in the following way/s: **(mark all that apply)** In the Dining Room with meals In my apartment At the Care Station where I will come to pick them up. Additional instructions:

Section 3 – All Residents

Other Comments: ____

____

Resident Signature: ________________________________ Date: ____________________

Changes in authorization will be made upon the resident's request by filling out a new form and attaching it to this form when completed. An opportunity to review theses authorizations shall be made at least annually.

Resident, please return this form with the Application Forms to the Office after you sign & date.

Staff Signature:_____________________________________ Date:____________________

C:\Users\Owner\Documents\Application packet\Resident Authorization.docx

Revised 8/29/2019

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503-743-2490

Medical Application

This side to be filled out by the applicant and signed by the physician

Today's Date: ____________________

Name: __________________________ Date of Birth: ______________ Social Security # __________________

Do you have an Advance Medical Directive? ☐ Yes ☐ No (please include copy with this form)

Do you have any allergies to medication? ☐ Yes ☐ No If yes, please list ______________

____

Please list the names and addresses of your physicians:

Primary Care Physician: __________________________________ Phone: ________________________________

Address: ____

Other Physicians

Physician:_____________________________ Physician:_______________________________

Specialty:_____________________________ Specialty:_______________________________

Phone:_______________________________ Phone:_________________________________

Address:_____________________________ Address:_______________________________

Complete and discuss with your physician

Diagnosis: **List medication:** **How often is med. taken:**

____________________________ ____________________________ ____________________

____________________________ ____________________________ ____________________

___________________________ ____________________________ ____________________

____________________________ ____________________________ ____________________

____________________________ ____________________________ ____________________

____________________________ ____________________________ __________________

I verify that this is a current list of medications

____ ____________

Physician's Signature Date

Authorization to Release Medical Information

I authorize medical information to be released to Turner Retirement Homes, Inc.

Name:____ Date of Birth:________________________________

Signature of Patient: ____Date:_________________________

Medical Statement to be filled out by Physician

This is a two page document. Physician fills out page 2 and also signs the bottom of both pages (1 & 2) after reviewing. Applicant needs to have a physical within the last three (3) months: Include current diagnosis, meds and disease.

Current medical status: ☐ excellent ☐ good ☐ fair ☐ poor

Immunizations: **Allergies:** (please list)

Pnumovax: Date:________________ ____________________________________

Influenza: Date:________________ ____________________________________

Tetanus: Date:________________ ____________________________________

Tuberculosis Clearance
(Chest X-Ray-Tine not accepted by State of Oregon)

Date:____________PPD:____________________Results:____

Current diagnoses and medications: (please verify list on page 1 with patient)

Any restrictions of diet activities: ☐ No ☐ Yes (if yes, explain) _________________________________

____

Is the patient able to perform all ADL's? ☐ No ☐ Yes (if no, explain)

____

I have examined ____ and found no evidence to support need for
(name of applicant/patient)
nursing home care at this time.

Date:____________________ Physician:______________________________ Telephone:_________________________
Signature

Address:____
Street City State Zip