MARTHA BALLARD ASSISTED LIVING

Dear Friend,

Thank you for considering the ***Martha Ballard Assisted Living*** Program located at Granite Hill Estates. There is an application and review process that potential residents must complete prior to being accepted. Therefore, please complete and return the enclosed forms. We will then schedule an appointment for the applicant to meet with our RN and Director of Assisted Living, to review the completed forms.

Please find enclosed the following forms:

- Physician's Medical Report (to be completed by applicant's Primary Care Physician) (one for each applicant)

- Application for Residence
- Resident Personal Care Representative Form
- Resident General and Supplemental Information Form (one for each applicant)
- Medication System Agreement
- Authorization to Release Health Care Information
- Hold Harmless Agreement
- Swimming Pool Policy

Please have each of the applicant's Primary Care Physician complete the Physician's Medical Report and have the doctor return the form to me at Granite Hill Estates. I have enclosed a self-addressed, stamped envelope for the doctor.

Please complete and sign the Application for Residence, the Resident Personal Care Representative Form, the Resident General and Supplemental Information Form, the Medication System Agreement, Authorization to Release Health Care Information and the Hold Harmless Agreement and return them to me as soon as possible.

Once all the forms have been returned to our office and reviewed, I will contact you to arrange an appoint to meet with you. Thank you for placing your confidence in the Martha Ballard Assisted Living Program. If you have any questions please contact me by calling toll free at
1-888-321-1119, locally at 207-626-7786 or by email at steven.roy@mainegeneral.org.
I am looking forward to working with you in the near future!

Sincerely,
Steven P. Roy
Steven P. Roy
Director of Sales and Marketing

GRANITE HILL ESTATES

MARTHA BALLARD ASSISTED LIVING

MaineGeneral Health

GRANITE HILL ESTATES

Application for Residence

To qualify for entrance to Granite Hill Estates you (or one of a couple) must be at least 62 years of age and able to meet Granite Hill Estates medical and financial criteria. Upon our receipt of this completed application and the physician's medical report, you will be contacted for an appointment to determine how best we might provide for your needs.

Applicant A:

Mr./Mrs./Miss/Ms._____Date of Birth _____
SS# _____Marital Status _____
Medicare# _____Medicare Supplement#_____
Do you currently have a long term care policy? Yes _____ No _____
If yes, does it cover assisted living services? Yes _____ No _____
Does it cover home health care services? Yes _____ No _____
If yes, policy company name and number _____

Applicant B:

Mr./Mrs./Miss/Ms._____Date of Birth _____
SS# _____Marital Status _____
Medicare# _____Medicare Supplement#_____
Do you currently have a long term care policy? Yes _____ No _____
If yes, does it cover assisted living services? Yes _____ No _____
Does it cover home health care services? Yes _____ No _____
If yes, policy company name and number _____

ADDRESS _____
Street

_____
City State Zip Code

TELEPHONE (_____) _____ EMAIL ADDRESS_____
Area Code Number

Accommodations Desired:

The Cottages	Maine Lodge	Assisted Living	Reflections - Memory Loss
_____ Two Bedroom	_____ One Bedroom	_____ One Bedroom	_____ One Bedroom
	_____ Two Bedroom	_____ Two Bedroom	_____ Two Bedroom
	_____ Efficiency		

Confidential Financial Statement (Required)

Monthly Income	**Applicant**	**Second Person**
Social Security		
Pension/Annuity		
Interest/Dividends		
All Other Income		
Total Income		

Assets		
Cash		
Savings Accounts		
Marketable Securities		
Residential Real Estate		
Other Real Estate		
Retirement Accounts		
Personal Property		
Other Assets		
Total Assets		

Liabilities		
Home Mortgage		
HELOC (Home Equity Loan)		
Credit Card Debt		
Other Debt		
Total Liabilities		

Does your pension/annuity continue for surviving spouse? Yes ___ No ___

Does your pension/annuity provide for annual adjustment? Yes ___ No ___

I/we hereby certify that I/we have adequate net income and net assets to meet all the anticipated expenses at Granite Hill Estates. Your signature is required below.

To the best of my/our knowledge, all the information on this application is complete and accurate. I/we understand that this information will be kept confidential and will be used only for the purpose of determining eligibility for admission and suitability of residence.

_____ _____

Signature Date

_____ _____

Signature Date

Durable Power of Attorney (Required, please provide copy)

Name: _____Relationship:_____

Address: _____

Telephone Number: _____Cell:_____

Work: _____Email: _____

Nearest Personal Representative (if different from above)

Name: _____Relationship:_____

Address: _____

Telephone Number: _____Cell:_____

Work: _____Email: _____

Do you have a Durable Power of Attorney? Yes ___ **(please provide copy)** No ___

Do you have a Living Will? Yes ___ **(please provide copy)** No ___

Do you have Health Care Directives? Yes ___ **(please provide copy)** No ___

Do you have a Long Term Care Insurance Policy? Yes ___ **(please provide copy)** No ___

Resident Personal Care Representative

To the Property Manager of Granite Hill Estates:

I hereby designate:

Name: _____

Address: _____

_____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Relationship: _____

_____

Resident's Signature

_____

Date

Acceptance

I agree to assume responsibility for _____,

a resident at Granite Hill Estates, in the capacity as stated above.

_____

Personal Care Representative's Signature

_____

Date

GRANITE HILL ESTATES

Resident General and Supplemental Information Form

(Please complete one form for each resident)

Resident Name: _____

Address: _____ Apt #: _____

Telephone: _____ Date Of Birth: _____ SSN: _____

Medicare Number: _____

Additional Insurance: _____

Allergies: _____

Primary Care Physician: _____Telephone: _____

Ophthalmologist: _____ Telephone: _____

Dentist: _____ Telephone: _____

Physician(s) – Specialty:

1. Name: _____

   Address: _____

Telephone Number: _____ Specialty: _____

2. Name: _____

Address: _____

Telephone Number: _____ Specialty: _____

3. Name: _____

Address: _____

Telephone Number: _____ Specialty: _____

Nearest Relative(s):

Please put in the order of which you would want us to contact in the event of an emergency.

1. Name: _____Relationship:_____

   Address: _____

   City: _____State:_____ Zip:_____

   Telephone Number:_____Cell:_____

   Work:_____Email:_____

2. Name: _____Relationship:_____

   Address: _____

   City: _____State:_____ Zip:_____

   Telephone Number:_____Cell:_____

   Work:_____Email:_____

3. Name: _____Relationship:_____

   Address: _____

   City: _____State:_____ Zip:_____

   Telephone Number:_____Cell:_____

   Work:_____Email:_____

Auto(s):

1. Year: _____ Make: _____ Color: _____

Plate #: _____ State: _____

2. Year: _____ Make: _____ Color: _____

Plate #: _____ State: _____

Optional:

Church Affiliation: _____

Minister's Name: _____ Phone:_____

College or University Attended: _____ Years:_____

MARTHA BALLARD ASSISTED LIVING

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Resident Name: _____ SSN# _____

DOB: _____ Telephone Number: _____

I authorize Granite Hill Estates and MaineGeneral Health to exchange health care information to/from:

_____ _____

_____ _____

_____ _____

_____ _____

My Primary care physician practice is: _____

And, they are covered by this consent.

I understand that:

* I can revoke my consent at any time prior to the release of records by delivering a written and dated notice of my wishes to staff of the Martha Ballard Assisted Living Unit. However, withdrawing my consent to release records may result in improper diagnosis, treatment; denial of insurance coverage or other adverse effects.

* I can refuse to disclose some or all of my records. However, such refusal may result in improper diagnosis, treatment, denial or insurance coverage or other adverse effects.

* I may have a copy of the document upon request.

Signed: _____ Date: _____

Resident or legally authorized representative (state relationship)

* This consent is valid for 30 months from date of signature, unless otherwise specified.

MARTHA BALLARD
ASSISTED LIVING

MEDICATION SYSTEM AGREEMENT

I, hereby agree as follows:

1. That from the date of this agreement, I will participate in the Medication System and will not self-administer or retain in my apartment any prescription medications of any kind, or

That I choose not to participate in the Medication System at this time, subject to the provisions in paragraph 4 below, and I understand that I am solely responsible for ensuring that all medications, prescription and non-prescription, are properly administered to me.

2. That all prescription medications may be obtained from a pharmacy of my choice however, we strongly recommend Winslow Pharmacy. Prescription and non-prescription medication will be administered to me by trained personnel of Granite Hill Estates.

3. That upon reasonable notice to Granite Hill Estates, I may withdraw from the Medication System at any time (subject to paragraph 4 below), but that I will then be solely responsible for ensuring that all medications, prescription and non-prescription, are properly administered to me.

4. That if I choose not to participate in the Medication System at this time or elect to withdraw from the Medication System, Granite Hill Estates, in its sole discretion, after consultation with me and my physician, may at any time determine that it is in my best interest that I participate in the Medication System and require me to do so. In the event such determination is made, I agree to release all prescription medications in my possession to Granite Hill Estates qualified staff and that I will then be subject to each of the provisions of this Agreement.

5. I understand that there are many interactions that may occur if I take over-the-counter medicines while receiving prescribed medications. Therefore, I agree to disclose to Granite Hill Estates qualified staff all over-the-counter medications I wish to maintain in my apartment and to promptly notify the licensed staff when I am taking any over-the-counter medicine. I also agree that I am solely responsible for the administration of all over-the-counter medicines and for any adverse reaction (s) that may result if I fail to disclose to and notify the staff as required by this paragraph.

6. That I will advise the licensed staff in advance when I will be unavailable to receive my regularly scheduled prescription medication (s) so that arrangements can be made to ensure that I receive them on time. I understand that if I do not notify the staff in advance, I am solely responsible for ensuring that I receive my medication (s) as scheduled.

Dated:_____

Resident Signature:_____

GRANITE HILL ESTATES

Hold Harmless Agreement

I, _____,

I, _____, (if a couple)

agree to hold harmless MaineGeneral Health and its entities, including Maine General Retirement Community (Granite Hill Estates), from and against any and all claims, actions, settlements, or judgments, based upon and arising out of the use of the Granite Hill Estates physical fitness facility, swimming pool, walking trails, and equipment therein. This hold harmless agreement applies to me, my family members, and my visitors, regardless of age.

It is further understood that under this agreement, the Granite Hill Estates physical fitness facility, swimming pool, walking trails and equipment therein is available for my personal use, and the use of my family members and my visitors. The manner and frequency with which the Granite Hill Estates physical fitness facility, swimming pool, walking trails, and equipment therein is used for this purpose is not in any way representative of MaineGeneral Health or any of its entities, including Granite Hill Estates.

I also understand that my use of the Granite Hill Estates physical fitness facility, swimming pool, walking trails, and equipment therein is unsupervised and that if a medical emergency occurs involving myself, or my family members or my visitors there may not be medical personnel in the area to respond. In this event, I hold MaineGeneral Health and its entities, including Granite Hill Estates, harmless.

I also acknowledge that I have received a copy of the Granite Hill Estates Pool Policy on this date: _____, _____.

Signature of above named individual: _____

Signature of above named individual: _____

Granite Hill Estates Representative:_____

GRANITE HILL ESTATES

Swimming Pool Policy

Residents use the pool and spa at their own risk.

- Residents will review and sign the Hold Harmless Agreement. Please return the signed copy to the front desk.
- Residents will be issued a key for the pool/spa area.
- Maintenance will open and regulate the pool/spa daily.
- In order to maintain proper decorum in our public areas, residents are not permitted to walk through Maine Lodge community areas in bathing attire. Appropriate knee length robes should be worn to cover bathing suits when walking to and from the pool area.
- Only pool clothing may be worn in the pool area. This includes bathing suits, bathing suit cover-ups, and pool shoes, such as sneakers or rubber soled swim shoes.
- Residents are encouraged to swim with a 'buddy' for their own safety.
- Formal programs are posted in the monthly calendar. The Life Enrichment Coordinator or another qualified individual conducts these scheduled programs.
- Items left in the lockers are done so at the resident's own risk.
- Wet bathing suits may not be worn in the hallways in order to avoid falls or damage to the carpeting. Residents must change into dry clothing before leaving the pool area.
- The pool/spa will close each day for maintenance and cleaning.
- The pool schedule may change from time to time.
- The maximum recommended time to be in the hot tub is 15 minutes.
- Guests and Family members must receive permission from management and sign the Hold Harmless Agreement before entering the pool area.

Please Note: Caution! Individuals suffering from heart disease, diabetes, high/low blood pressure, should not use the spa without checking with your physician first. Also, individuals under the influence of alcohol, anticoagulants, antihistamines, vasoconstrictors, stimulants, hypnotics, narcotics or tranquilizers should not use the spa.

GRANITE HILL ESTATES

Dear Doctor:

Granite Hill Estates is a Continuing Care Retirement Community (CCRC), owned by MaineGeneral Health, for individuals and couples, 62 and older, designed to provide the supportive services needed to maintain the highest level of independence possible within a residential campus environment. In fulfilling this mission, we offer a variety of housing options and services as described in this letter.

Residents in the ***Cottage-style homes*** (individual homes) and ***Maine Lodge Apartments*** must be functionally independent and able to meet ADLS with little or minimal assistance. We support efforts to maintain this independence via one meal a day in our central dining room, a continental breakfast; a full activities program which includes educational, social, and cultural events; transportation for local medical appointments, property maintenance, housekeeping, health services coordinated by a registered nurse-administrator; and a 24-hour emergency call system, which connects directly to 911.

Residents in the ***Martha Ballard Assisted Living Neighborhood*** must be essentially ambulatory, continent, oriented and be able to meet ADLS with up to moderate personal assistance. These residents will receive three meals a day in a central dining room, linen and laundry service, housekeeping, a full activities program, transportation for local medical appointments, and administration of medications; and program oversight by a licensed nurse and a 24-hour on-site staff of personal care attendants.

Our ***Reflections Neighborhood*** is dedicated to serving persons with early memory loss. Offering similar daily services as our assisted living program, ***Reflections*** is enhanced with additional programs and expertly trained staff to provide superb care with compassion and respect 24/7.

Acceptance into Granite Hill Estates cannot be given until we receive and review this completed medical report. We thank you in advance for your time and cooperation and welcome any inquiries you may have. Please feel free to contact us toll free at 1-888-321-1119 or locally at (207) 626-7786.

Granite Hill Estates Management

PHYSICIAN'S MEDICAL REPORT

for

Applicant's Name

_____

Physician:

Dr. _____

Address _____

_____

Telephone _____

I hereby authorize the above physician to release medical information as requested by Granite Hill Estates. This information is confidential and will be used only for the purposes of determining eligibility for residence, suitably of unit selection, and coordination of supportive services. I reserve the right to revoke or change this release at any time. The consent expires in one year.

Applicant's signature _____

Date: _____

Physician's Medical Report

60 Balsam Drive, Hallowell, Maine 04347
207-626-7786 1-888-321-1119 fax 207-626-7762
e-mail: steven.roy@mainegeneral.org

1. Please provide your medical opinion regarding the applicant's overall condition - check below:

B. Good _____ (minor limitations)

C. Fair _____ (moderate functional limitations requiring some assistance with ADLs)

D. Poor _____ (severe functional limitations requiring a high level of assistance with ADLs)

If C or D, please give details of limitations _____

_____

2. Date of last physical exam_____

3. Date of Birth _____ Height _____ Weight_____

4. Drug allergies _____

5. Dietary restrictions _____

6. Systems Review: Please describe in detail any appropriate diagnostic/health conditions pertinent to this applicant. Use extra space if necessary.

A. Cardio/Vascular _____

_____

B. Pulmonary _____

_____

C. Gastro/Intestinal _____

_____

D. Endocrine _____

_____

E. Genitourinary _____

_____

F. Neurological _____

_____

G. Musculoskeletal _____

_____

H. Ophthalmic _____

_____

I. Dermatologic _____

_____

J. Psychiatric _____

_____

7. Past major medical/surgical history:

Condition	Date	Treatment/Status/Comments

8. Please list any medications (prescription and non-prescription) the applicant is currently taking.

Name of Drug	Dosage/frequency	Condition for which taken

9. Medication administration:

   Self-administered _____ Minimal supervision _____ Complete supervision _____

10. Physical exam:

    B/P _____ Pulse _____ Extremities_____

    Neurological _____ Motor strength _____

    Hearing loss _____ Hearing aid _____

11. Smoker _____ Non-smoker _____ How Long _____

12. Extent of alcohol consumption _____

13. The following questions pertain to the applicant's functional capabilities and will help to determine the most suitable residence and support services to best meet needs (cottage, apartment or assisted living).

    A. Does this applicant require any ASSISTANCE IN MOBILITY? Yes _____ No _____
    If yes, please explain physical limitation _____
    If no, is the applicant's mobility dependent on any DEVICES?
    (wheelchair, walker, cane, braces, commode, hospital bed, artificial limb)?

    Yes _____ No _____ If yes, please describe _____

    _____

B. Does this applicant require any PERSONAL CARE ASSISTANCE in such areas as bathing, dressing, personal hygiene, housework and/or medication administration? Yes _____ No _____

If yes, please explain _____

C. Does the applicant have any impairment that would prohibit him/her from participating in the meal program in the central dining room? Yes _____ No _____

If yes, please explain _____

D. Is the applicant capable of preparing two meals a day safely and appropriately, including any dietary considerations? Yes _____ No _____ If no, please explain _____

_____

E. Is the applicant capable of using a telephone?
Yes _____ No _____ If no, please explain _____

F. Is the applicant FULLY CAPABLE of exercising good judgment in decision making on personal matters? Yes _____ No _____ If no, what areas might the applicant require assistance?

_____

G. Does this applicant ever experience anxiety, depression, paranoia or phobias which interfere with activities of daily living? Yes _____ No _____ If yes, please explain _____

_____

H. Does this applicant have any behaviors, traits or habits that impair his/her ability to live with others? Yes _____ No _____ If yes, please explain _____

_____

I. Are there any other physical/medical problems that we should be aware of that might inhibit this applicant from successfully living in our community environment? Yes _____ No _____

If yes, please explain _____

_____

14. Do you feel that Granite Hill Estates is a suitable residence for the applicant? Yes ____ No ____

If yes, which part of our community would you consider most appropriate?
(Please see description of each community below).

Cottage Community _____ (Resident is able to function without assistance)

Maine Lodge Apartment Community _____ (Resident is able to function without assistance)

Assisted Living Community _____ (Resident requires assistance with ADL's (Activities of Daily Living)

Reflections Neighborhood _____ (Resident has early memory loss and requires assistance with ADL's) (Activities of Daily Living)

Physician's signature _____ Date: _____

The management staff of Granite Hill Estates thanks you for your time!