THE CEDARS
OF CHAPEL HILL

Date: _____
Finance Approved: _____

CONFIDENTIAL MEMBERSHIP APPLICATION
EXHIBIT A

PERSONAL DATA

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Email: _____

Social Security No.: _____ - _____ - _____ Birthdate: _____

Marital Status: Single _____ Married _____ Widow(er) _____

SPOUSE OR SECOND PERSON

Name: _____ Relationship: _____

Email: _____

Social Security No.: _____ - _____ - _____ Birthdate: _____

OTHER CONTACT PERSONS (Children or nearest relatives)

Name: _____ Relationship: _____

Address: _____ Zip: _____ Telephone: _____

Email: _____

Name: _____ Relationship: _____

Address: _____ Zip: _____ Telephone: _____

Email: _____

FINANCIAL DATA

Approximate Assets (Net of all Debt):	Amount	Comments
1. Equity in Residence	$ _____	_____
2. Savings, CD's (and other liquid assets)	$ _____	_____
3. Stocks	$ _____	_____
4. Bonds	$ _____	_____
5. IRA	$ _____	_____
6. Trusts	$ _____	_____
7. Combined Net Assets:	$ _____	_____

APPROXIMATE GROSS MONTHLY INCOME

	Applicant	Spouse or Second Person
1. Social Security	$ _____	$ _____
2. Pension and Retirement	$ _____	$ _____
(If this amount changes for spouse in the event of applicant's death, please state how much)		$ _____
3. Other Income (Please specify on back of sheet)	$ _____	$ _____
TOTAL GROSS MONTHLY INCOME:	$ _____	$ _____

MEMBER INSURANCE INFORMATION

	Applicant	Spouse or Second Person
Medicare Number:	_____	_____
Supplemental Hospital Insurance Carrier and Policy Number:	_____	_____
Long-Term Care Insurance:	Yes: _____ No: _____	Yes: _____ No. _____
Are you a smoker?	Yes: _____ No: _____	Yes:_____ No:_____

MEMBER HEALTH INFORMATION

Do you need assistance with the following?

	FIRST PERSON		SECOND PERSON	
	Yes	**No**	**Yes**	**No**
1. Eating	_____	_____	_____	_____
2. Walking (equipment such as a cane, crutches, walker, wheelchair, and scooter will not be considered assistance)	_____	_____	_____	_____
3. Transferring	_____	_____	_____	_____
4. Toileting	_____	_____	_____	_____
5. Bathing	_____	_____	_____	_____
6. Grooming	_____	_____	_____	_____
7. Dressing	_____	_____	_____	_____
8. Taking medications	_____	_____	_____	_____
9. Handling financial matters	_____	_____	_____	_____
10. Handling personal matters	_____	_____	_____	_____
11. Ability to obtain items needed for daily living	_____	_____	_____	_____
12. Other (please explain below)	_____	_____	_____	_____

For each activity you require assistance with as noted above, please explain how your need will be met and provide the number of minutes of assistance needed PER DAY for each activity.

FIRST PERSON

_____

_____

_____

SECOND PERSON

_____

_____

_____

For all activities identified above for which you need assistance, are you willing to obtain DuBose Home Care or another provider for assistance at your own expense? FIRST PERSON ____Yes ____No SECOND PERSON ____Yes ____No

Are you ambulatory to the extent that in case of emergency you would be able to get to safety without assistance? This would not preclude the use of equipment such as a cane, crutches, walker, wheelchair, or scooter, if it allows you to get to safety.

FIRST PERSON: Yes _____ No _____ **SECOND PERSON**: Yes _____ No _____

If no, please explain. _____

Do you have active Tuberculosis or a history of Tuberculosis?
FIRST PERSON: Yes _____ No _____ **SECOND PERSON**: Yes _____ No _____

Do you have one (or more) of the following health condition(s) diagnosed by a physician: (1) Parkinson's; (2) Chronic Obstructive Pulmonary Disease (COPD) including emphysema; (3) Congestive Heart Failure (CHF); (4) metastatic cancer; (5) osteoporosis with a history of fractures; or (6) Dementia?
FIRST PERSON: Yes _____ No _____ **SECOND PERSON**: Yes_____ No_____

If yes, please identify:
FIRST PERSON: _____

SECOND PERSON: _____

Misrepresentation by the Prospective Member

If the prospective Member misrepresents either intentionally or unintentionally any information provided during the membership process and subsequently becomes a Member of The Cedars, The Cedars, upon discovering the misrepresentation, may revoke the Member's right to reside at The Cedars pursuant to the terms of the Membership Agreement.

I HEREBY STATE THAT ALL INFORMATION PROVIDED IN THE CONFIDENTIAL MEMBERSHIP

APPLICATION FORM IS TRUE ON THIS _____ DAY OF _____, 20_____.

_____ _____
FIRST PERSON Witness

_____ _____
SECOND PERSON Witness

_____ _____
The Cedars of Chapel Hill L.L.C. Witness
Marketing Representative

The Cedars is committed to providing quality care and services to people of all race, color, religion, or natural origin