STONERIDGE CREEK PLEASANTON
EXPECT MORE FROM RETIREMENT.

CONFIDENTIAL

APPLICATION FOR RESIDENCY

A. APPLICANT #1

Name ____
(Dr./Mr./Mrs./Ms./______) Last First Middle

Address ____

City ____________________ State ____________ ZIP ____________

Email address ____

Telephone ____________________ Cell ____________________

Place of Birth ____________________ Date of Birth ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er

☐ Registered Domestic Partnership

B. APPLICANT #2

Name ____
(Dr./Mr./Mrs./Ms./______) Last First Middle

Address ____

City ____________________ State ____________ ZIP ____________

Email address ____

Telephone ____________________ Cell ____________________

Place of Birth ____________________ Date of Birth ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er

☐ Registered Domestic Partnership

C. How are the first and second applicants related? ____________________

If Married, Anniversary Date ____________________

D. Other than your spouse, does anyone else live with you?

☐ Yes ☐ No

E. Business or Profession (former if retired):

Applicant #1 ______________________

Employer (most recent) ______________________

Applicant #2 ______________________

Employer (most recent) ______________________

F. Hobbies, Interests, Community Activities:

Applicant #1 ______________________

____

Applicant #2 ______________________

____

G. Children and/or Close Relatives:

1. Name ______________ Relationship ______________

   Address ______________________

   City ______________ State ________ ZIP ________

   Cell ______________ Email ______________

2. Name ______________ Relationship ______________

   Address ______________________

   City ______________ State ________ ZIP ________

   Cell ______________ Email ______________

3. Name ______________ Relationship ______________

   Address ______________________

   City ______________ State ________ ZIP ________

   Cell ______________ Email ______________

H. How did you become aware of Stoneridge Creek?

☐ Website ☐ Direct Mail ☐ Seminar ☐ Referral ☐ Other

If other, please specify: ______________________

I. Why are you interested in becoming a resident of Stoneridge Creek?

☐ Quality of Project ☐ Services/Amenities ☐ Location ☐ Long Term Care

☐ Family in Area ☐ All of the Above

If other, please specify: ______________________

APPLICANT FINANCIAL STATEMENT

Stoneridge Creek must ascertain whether or not each applicant(s) will have sufficient funds from income and/or assets to pay the entrance fee and monthly service fee, plus a reasonable amount for personal expenses.

Please list below your assets and liabilities.

ASSETS AT CURRENT VALUE		LIABILITIES	
Home (Schedule on page 4)	$ ________	Home Mortgage (Schedule on page 4)	$ ________
Other Real Estate (Schedule on page 4)	$ ________	Loans/Other Real Estate (Schedule on page 4)	$ ________
*Listed Stocks & Bonds (Non-IRA)	$ ________	Notes Due Bank	$ ________
IRA	$ ________	Notes Due Others	$ ________
*Cash Savings, Money Market Accounts, etc.	$ ________	Notes Due Others	$ ________
Total Assets	$ ________	**Total Liabilities**	$ ________
Net Worth (Total Assets – Total Liabilities): $ ________			
*Other	$ ________	*Other Liabilities	$ ________
*Personal Property (describe)	$ ________		

* Explain the investments listed above and indicate how they relate to monthly income.

____

____

____

APPLICANT FINANCIAL STATEMENT

REAL ESTATE

Please list all properties owned, including your current residence.

Address and Description (Income/ Non-Income)	Date Acquired	Original Cost	Current Value	Amount Owing	Monthly Payments	Payable to Whom

If you guarantee loans for others, please give details:

____

____

____

Please complete this section for notes due you:

Borrower	Date of Note	Amount Borrowed	Payments	Due Date

APPLICANT MONTHLY INCOME STATEMENT

	Applicant #1		Applicant #2	
	Current Income (Monthly)	Income to Surviving Applicant (Monthly) **	Current Income (Monthly)	Income to Surviving Applicant (Monthly) **
Social Security Benefits				
Pension (Non-IRA)				
Annuities*				
Trust Funds*				
Dividends/ Interest/IRA				
Real Estate*				
Other (describe)				
Total				

Adjusted gross income (AGI) for most recent tax year: $________________ Year: ____________

* Explain the incomes listed above as they relate to specific investments.

____

____

____

****List in chart above any income passed on to surviving applicant (Example: If ½ of $1000.00 Pension (Non-IRA) goes to Applicant #2 upon Applicant #1's death, list $500.00 in the corresponding box under "Income to Surviving Applicant (Monthly)."**

APPLICANT MONTHLY INCOME STATEMENT

1. Does your non-social security pension or retirement income include cost of living increases?

   ☐ Yes ☐ No

2. How much life insurance do you own (Applicant #1)? ______________________

   Beneficiary: ______________________ Cash Value: ______________________

3. How much life insurance do you own (Applicant #2)? ______________________

   Beneficiary: ______________________ Cash Value: ______________________

4. Are you a participant in a prenuptial agreement?

   ☐ Yes ☐ No

5. Are there restrictions on your assets in the event of your death?

   ____

6. Are you paying or receiving alimony?

   ☐ Yes ☐ No

   If yes to Question 6, what are the terms? ______________________

   ____

Attorney ____

Phone ____

Email Address ____

Permission to Contact ☐ Yes ☐ No

Financial Advisor or Accountant ____

Phone ____

Email Address ____

Permission to Contact ☐ Yes ☐ No

PERSONAL HEALTH INFORMATION

APPLICANT #1

Name ______________________________

Gender ____________ Gender Identification ____________ Age ____________

APPLICANT #2

Name ______________________________

Gender ____________ Gender Identification ____________ Age ____________

	Applicant #1		**Applicant #2**	
Are you enrolled in the Medicare program?	☐ Yes	☐ No	☐ Yes	☐ No
Are you enrolled in Medicare Part A?	☐ Yes	☐ No	☐ Yes	☐ No
Are you enrolled in Medicare Part B?	☐ Yes	☐ No	☐ Yes	☐ No

If NO, please explain: ______________________________

Please list other health insurance policies or HMO plans in which you are enrolled:

Applicant #1 ______________________________

Applicant #2 ______________________________

	Applicant #1		**Applicant #2**	
Do you presently have long-term care insurance?	☐ Yes	☐ No	☐ Yes	☐ No

If YES, name of company: ______________________________

Type of coverage:
☐ Assisted Living ☐ Skilled Nursing ☐ Memory Care ☐ Home Care

Applicant #1

General health is	☐ Good	☐ Average	☐ Fair	☐ Poor
Vision is	☐ Good	☐ Average	☐ Fair	☐ Poor
Hearing is	☐ Good	☐ Average	☐ Fair	☐ Poor

Color of hair __________ Color of eyes __________ Weight __________ Height __________

If you have any allergies, indicate what they are: ______________________________

____

Applicant #2

General health is	☐ Good	☐ Average	☐ Fair	☐ Poor
Vision is	☐ Good	☐ Average	☐ Fair	☐ Poor
Hearing is	☐ Good	☐ Average	☐ Fair	☐ Poor

Color of hair __________ Color of eyes __________ Weight __________ Height __________

If you have any allergies, indicate what they are: ______________________________

____

PERSONAL HEALTH INFORMATION

During the last five years, have you received medical advice or treatment, or been confined to a hospital, any type of nursing home, or convalescent care facility for any of the following conditions?

	Applicant #1		Applicant #2	
A. Nervous, mental, emotional disorder; depression; mild cognitive impairment (MCI), dementia, Alzheimer's disease, Parkinson's disease, or other neurologic disorders?	☐ Yes	☐ No	☐ Yes	☐ No
B. Cancer, tumor or other growth?	☐ Yes	☐ No	☐ Yes	☐ No
C. Heart attack; stroke; heart disease, congestive heart failure (CHF), high blood pressure or other circulatory system disorder? Emphysema; chronic obstructive pulmonary disease (COPD), oxygen use or other respiratory system disorder?	☐ Yes	☐ No	☐ Yes	☐ No
D. Liver, kidney, diabetes or digestive system disorder, colostomy or ileostomy?	☐ Yes	☐ No	☐ Yes	☐ No
E. Rheumatism; arthritis, back, spine, bone, muscle or other joint disorder; paralysis or prosthetic device?	☐ Yes	☐ No	☐ Yes	☐ No
F. Been confined, or has confinement been recommended, to a hospital, a nursing home or home for the aged, or any other institution or care center?	☐ Yes	☐ No	☐ Yes	☐ No
G. Received partial or total disability benefits?	☐ Yes	☐ No	☐ Yes	☐ No
H. Do you have any communicable disease?	☐ Yes	☐ No	☐ Yes	☐ No
I. Do you need assistance or supervision of any kind to perform everyday living activities?	☐ Yes	☐ No	☐ Yes	☐ No
J. Do you use any medical appliance or assistive device, such as wheelchair, walker, cane, or hospital bed?	☐ Yes	☐ No	☐ Yes	☐ No

PERSONAL HEALTH INFORMATION

For "yes" answers to questions A through J, please provide details on this page. Attach additional sheets if necessary.

Applicant #1

A. ______________________________

B. ______________________________

C. ______________________________

D. ______________________________

E. ______________________________

F. ______________________________

G. ______________________________

H. ______________________________

I. ______________________________

J. ______________________________

Please list all current medications, including all routine injections.

____

____

Applicant #2

A. ______________________________

B. ______________________________

C. ______________________________

D. ______________________________

E. ______________________________

F. ______________________________

G. ______________________________

H. ______________________________

I. ______________________________

J. ______________________________

Please list all current medications, including all routine injections.

____

____

PERSONAL HEALTH INFORMATION

Physician (Applicant #1) ______________________________

Address ______________________________
Street City State ZIP

Physician (Applicant #2) ______________________________

Address ______________________________
Street City State ZIP

Hospitals in which you have been a patient in the last five years:

Applicant #1

1. Name ______________ City ______________ State ______
2. Name ______________ City ______________ State ______
3. Name ______________ City ______________ State ______

Applicant #2

1. Name ______________ City ______________ State ______
2. Name ______________ City ______________ State ______
3. Name ______________ City ______________ State ______

I/We understand that if the Application for Residency is approved by Stoneridge Creek, the Application for Residency and all the information supplied within the Application for Residency, including but not limited to the Applicant Financial Statement, the Applicant Monthly Income Statement and the Personal Health Information report, will become a part of the Residence and Care Agreement at the time I/we become a resident, and that any misrepresentation, concealment, or omission may cause the Residence and Care Agreement to be voided at the sole discretion of Stoneridge Creek.

Applicant #1 Signature ______________________ Date ____________

Applicant #2 Signature ______________________ Date ____________

If someone other than the Applicant has completed all or part of this form, please provide the following information.

____
Name Address City, State

____
Relationship to the Applicant Phone Number Signature

EQUAL HOUSING OPPORTUNITY