BLUFF HAVEN WAIT LIST

To whom it may concern:

You are receiving this packet because you or a loved one has shown interest in living at Bluff Haven Assisted Living or Residence at Bluff Haven (independent apartments with services) in Prairie du Chien, Wisconsin either by calling our office or stopping in.

Packet includes: Wait list Agreement, Application for Residency, a Health screen questionnaire, a POA-Finances/Insurance information, and a request for a wait list fee of $200-paid by cash or check only.

We have decided to change our standards for our wait list in order to increase better communication between those on the wait list and those in Administration.

*Current care package costs at Bluff Haven are subject to change at any time. If you would like rates mailed to you, please call Administration at (608) 326-8472.

Sincerely,

Alesha M. Erdenberger
Administrator of Prairie Memorial Housing, LLC
Senior Vice President of Operations
Community Health Services Corporation
720 South Fremont Street
Prairie du Chien, WI 53821
Office (608) 326-3200
ame@chscwi.org
website: chscwi.org

WAIT LIST/ RESIDENCY AGREEMENT

Bluff Haven Assisted Living/ Residence at Bluff Haven
Licensed Assisted Living and Independent Living with Supportive Services

WAIT LIST FEES

The wait list fee is $200.00, due upon submission of an application, which includes a $50.00 nonrefundable processing fee. The remainder of the wait list fee ($150.00) will be applied to the first month's rent if you move into any CHSC's facilities or refunded after a request to be removed from the wait list.

To be removed from the wait list, you must contact either the Administrator or the Assistant Administrator of Bluff Haven Assisted Living and a check in the amount of $150.00 will be refunded to you within 30 days of your request.

PROCESS FOR GETTING ON WAIT LIST

The process to get on the waiting list is very simple. An interested person needs to fill out the application. Once completed mail the completed application with a $200.00 check for the waiting list fee. Once these 2 items are received a resident is placed on the waiting list.

One's place on the waiting list is determined by the date on which all application materials are received. These materials consist of the following items, which must be completed in full:

1. Application for Residency
2. Financial & Health Insurance Information
3. Pre-screen Questionnaire (completed by staff) * *Please make an appointment.*
4. Application/Assessment Processing Fee of $200.00
   (If you are currently on the Continus/Family Care program, the application fee is waived.)

Applicants are considered for placement based on one of the two (2) priorities below based on their current living status, medical condition and rehabilitation needs. The priorities are summarized as follows:

Priority 1 (Served first): Residents currently residing at any C.H.S.C.'s facilities: Sannes Skogdalen Heim, Prairie Maison, LaBatisse on Dousman Apartments, and Bluff Haven- upon each opening at Bluff Haven communication will take place at each facility to see if a current resident would like to be assessed for placement.

Priority 2 (Served after Priority 1): Applicants at home or another assisted living facilities. These applicants must provide Bluff Haven with:

- Medical records released from Physician that includes current diagnoses and medications, including dosage and route of administration.

- A recent history and physical examination by the referring physician.
- The most recent chest X-ray report (Must be within 90 days of admission).
- A pre-admission screening completed by Nurse at Bluff Haven.

NOTICE PERIOD

Current residents take priority on the Assisted Living waiting list. When a room becomes available the people on the wait list are contacted starting at the top of the waiting list. A potential resident has **2 days** to determine if they are interested in proceeding with the assessment process at that time. If the room is declined at that time a potential resident will not lose their spot on the waiting list, but will merely be passed up at the time for the current opening.

We continue to call down the waiting list until a potential resident expresses interest in residency. At that time the assessment process is initiated. Although a potential resident has been added to the waiting list, final approval for residency is contingent upon the assessment process and Assisted Living residency requirements.

If you accept, Bluff Haven staff will schedule a time for you to come in to:

- Sign the residency agreement
- Pay the remainder of the monthly rental fee starting on the day after acceptance

By signing below, I acknowledge that living at other CHSC facilities and being on the wait list doesn't guarantee admission to any facilities at Bluff Haven.

To place your name on the wait list, send this completed agreement and your $200 wait list fee to:

Bluff Haven
Attn: Admissions
720 South Fremont Street
Prairie du Chien, WI 53821
(608) 326-8472

To be removed from the wait list, you must contact the Admissions Coordinator.

I have read and understand the wait list policies. I understand that the remainder of the wait list fee ($150.00) will be applied to the first month's rent if I move into any CHSC's facilities or refunded after a request to be removed from the wait list.

Signature of applicant _____ Date _____

Signature of Spouse _____ Date _____

APPLICATION FOR RESIDENCY / WAIT LIST

Bluff Haven Assisted Living/ Residence at Bluff Haven
720 South Fremont Street
Prairie du Chien, WI 53821
(608) 326-8472

Licensed Assisted Living and Independent Living with Supportive Services

Bluff Haven Apartment Preference:

☐ - Studio ☐ - 1 Bedroom ☐ - 2 Bedroom * Must be occupied by two people

Your preference for the size of room will depend on the resident care needs.

Application Filled out by: _____

Full Name of Potential Resident: _____

Relationship to Potential Resident: _____

Present Address _____
(Mailing Address) (City) (State) (Zip)

Telephone Number _____ Marital Status _____
(Married, Unmarried, Separated)

Social Security Number _____ Sex _____ Date of Birth _____

Spouse/Co-Tenant _____ Age _____

Spouse Soc. Sec. No. _____ Sex _____ Date of Birth _____

Occupation/ past_____

I would like the following individual(s) to be contacted regarding an apartment offer:

Contact Name: _____

Relationship to Potential Resident: _____

Mailing Address: _____

Primary Phone: _____

Secondary Phone: _____

Email Address: _____

Miscellaneous Info: _____

Personal References

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

**Referred to Bluff Haven by: _____

Do you currently drive, if so:

List vehicle to be parked at premises: _____
Make Model Year

Credit/Criminal History

Bank Name _____ Phone _____

Address _____

Have any of the occupants listed above ever been: convicted of a felony?_____ Received deferred adjudication for a felony?_____Been evicted?_____Broken a lease? _____ _____Declared bankruptcy? _____. The above listed applicant declared that all statements made in this application are true and complete.

Applicant hereby authorizes Community Health Services Corporation (Landlord) to verify all of the information in this application and obtain credit reports on the above listed applicant and/or applicant's. If applicant or applicant's spouse has given any false information The facility is entitled to reject the application.

You are also consenting to the release of medical information and have agreed to provide the necessary information and forms for admission for residency.

Signature of applicant _____ Date _____

Signature of Spouse _____Date _____

Thank you for your information and interest, please inform us when something changes on your application.

HEALTH SCREEN QUESTIONNAIRE

Bluff Haven Assisted Living/ Residence at Bluff Haven

Licensed Assisted Living and Independent Living with Supportive Services

1. PERSONAL DETAILS

Name: _____ Given Names: _____

Address: _____

Phone: _____

Date of Birth: _____

Is the potential resident's Power of Attorney for Health Activated by Two Physicians to state they are unable to make all healthcare decisions? **YES/NO**

If so, please attach.

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2. MEDICAL HISTORY

How long since your last medical check up? _____

Regular Doctor's Name _____ / Doctor's Clinic_____

Are you taking any prescribed medications? **YES/NO** If yes, provide a list attached.

Have you had any major injuries/surgeries during the last three years? **YES/NO** If yes, provide a list attached.

Have you ever suffered from the following or have a family history of any of them?

a) Asthma or breathing difficulties...YES/NO
b) Pain/tightness in the chest…….YES/NO
c) High Blood Pressure……. YES/NO
d) High cholesterol/triglycerides…….YES/NO
e) Rheumatic fever…….…... YES/NO
f) Any heart/stroke condition……... YES/NO
g) Gout……... YES/NO
h) Dizziness……..... YES/NO
i) Diabetes…….. YES/NO
j) Chronic cough…….…... YES/NO

k) Stomach ulcer……..….... YES/NO

l) Liver/kidney condition……... YES/NO

m) Arthritis/joint pain……..….... YES/NO

n) Muscular pain……..….... YES/NO

o) Lower back pain……..….... YES/NO

p) Hernia…….……..... YES/NO

q) Cramps…….……... YES/NO

r) Circulation problems……... YES/NO

s) Parkinson's disease……..... YES/NO

t) Dementia…….……..... YES/NO

u) Alzheimer's disease…….…. YES/NO

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3. LIFESTYLE

Do you consider your diet to be: GOOD ADEQUATE POOR

Do you have any dietary requirements? MECHANICAL SOFT DIABETIC
CARDIAC PRUDENT THICKENED LIQUIDS

More: _____

How do you rate your stress level? HIGH MODERATE LOW

Do you smoke? YES/NO How many per day? _____

BLUFF HAVEN ASSISTED LIVING/RESIDENCE AT BLUFF HAVEN

CONFIDENTIAL FINANCIAL STATEMENT

For purposes of applying for admission to either **Bluff Haven Assisted Living or Residence at Bluff Haven** ("Facility"), I am providing the following complete and accurate description of my financial condition.

BACKGROUND.

Name:_____

Date of Birth:_____

Address:_____

Marital Status:_____ If married, name of spouse:_____

INCOME. Please identify your monthly income. If you are married or plan to live with another person while living at Bluff Haven, please include the income of your spouse/roommate. If you receive a type of income that is not listed, please use the "other" category to identify this income. Unless expressly noted, you represent that all income is available to pay for your care and/or services. All boxes should be completed. If a source of income is not applicable, mark "N/A" in the box. Please use additional pages as necessary.

Monthly Income	Applicant (per month)	Spouse (per month)
Social Security	$	$
Veterans Benefits	$	$
SSI (Supplemental Security Income)	$	$
Alimony	$	$
Unemployment Compensation	$	$
Pension	$	$
Retirement Plans	$	$
Disability Plans	$	$
Income from Stocks and Bonds	$	$
Rental Income Paid to You	$	$
Annuities	$	$
Trust Fund	$	$
Interest Income from Savings	$	$
Other: Description_____ _____	$	$
Total Monthly Income	$	$

<u>ASSETS</u>. Please list your current assets. If an asset is owned by a trust, indicate the name and type of trust. If an asset is jointly owned, identify the other owners and your percentage of ownership. Unless expressly noted, you represent that the listed assets are available to pay for your care and/or services. All boxes should be completed. If an asset type is not applicable, mark "N/A" in the box. Please use additional pages as necessary.

Assets	Mark If Applicable	Who owns (applicant, spouse, jointly, trust). If joint, identify co-owner. If trust, identify name of trust.	Amount
Checking Account/Name of Bank _____ Interest Bearing Yes/No Account #_____			$
Checking Account/Name of Bank _____ Interest Bearing Yes/No Account #_____			$
Savings Account/Name of Bank _____ Account #_____			$
Cash on Hand			$
Stocks: Description_____ _____			$
Bonds: Description_____ _____			$
Certificates of Deposit			$
Money Owed to You			$
Real Estate Owned: Description_____ _____			$
Land Contract			$
Farm Equipment			$
Livestock			$
Vehicles			$
Other: Description_____ _____			$

<u>* Please use additional pages as necessary.</u>

TRANSFER OF ASSETS. Please identify any assets or other financial resources worth over $5,000 that you have given away or sold for less than fair market value within the last year five years. Please use additional pages as necessary.

Description of What Was Sold or Given Away:_____
By Whom:_____
To Whom:_____
Date of Gift or Sale:_____
Total Market Value:_____
Amount Received:_____

LIABILITIES. Indicate any significant liabilities that you owe. All boxes should be completed. If a liability is not applicable, mark "N/A" in the box. If a liability type is not listed, please use the "other" category to identify those liabilities. Please use additional pages as necessary.

Liabilities	Mark If Applicable	Amount
Credit Cards		$
Taxes		$
Medical Bills		$
Loans: Description: _____ _____		$
Health Insurance Costs		$
Other: Description_____ _____		$

POWER OF ATTORNEY FOR FINANCES.
Do you have a Power of Attorney for Finances: Yes___ No___. If yes, please provide name of agent:_____

MEDICARE.
Are you enrolled in Medicare Part A? Yes __ No __. If you are not eligible, do you have an equivalent insurance policy? Yes __ No __.
Do you have a supplemental Medicare policy ("Medigap")? Yes __ No __.

LONG TERM CARE INSURANCE.
Do you have long-term care insurance? Yes __ No __. If yes, provide name of insurance company:_____
Primary Insurance:_____ Secondary Insurance:_____

LIFE INSURANCE.
Do you have life insurance? Yes __ No __. If yes, provide the following:
Cash Value:_____
Face Value:_____
Company Name:_____
Date Issued:_____

ACKNOWLEDGEMENT.
By signing this form, I represent and warrant that the above information is true and correct and accurately reflects my financial condition and the resources that are available to pay for my care and/or services. I understand that Facility will be relying on the information provided herein and may terminate any and all agreements with me, if I provide false or misleading information. I further give Facility permission to verify the information provided herein. I also understand that I may be required to provide supporting documentation regarding the financial data I have provided and provide updated financial information and agree to do so upon request. I believe I have adequate resources to meet my financial responsibilities, including those that will attach if I am accepted into Facility.

_____ _____
Signature of Prospective Resident Date

If prospective resident is unable to sign, complete the following:

Name of Personal Representative:_____
Authority to Act:_____
Address:_____
Home Telephone Number:_____
Work Telephone Number:_____

_____ _____
Signature of Personal Representative Date

FOR FACILITY USE ONLY:
Received on _____
by _____.