



RiverMead

LIFECARE  
WITH LIFESTYLE

# RIVERMEAD

## ASSISTED LIVING WAITLIST

### Waitlist Process:

- ◆ Fill out the Waitlist Agreement, the Confidential Data Application, the Resident Representative Form, the Authorization to Release Medical Information Form and the Resident Billing Information Form and return to RiverMead
- ◆ Payment of a **\$2,000 refundable** Waitlist Deposit which is applied to the Entrance Fee and a **\$250 non-refundable** Application Fee
- ◆ Your name is entered chronologically onto the Waitlist by the date you join.
- ◆ You can place your name on the list for more than one style of assisted living suite/room.
- ◆ When a suite/room becomes available, the first person on the list will be contacted & offered that accommodation
- ◆ There are three opportunities to turn down an accommodation before being placed at the bottom of the list

Please read the Waitlist Agreement carefully. If you have any questions, please call Jan Eaton, Director of Resident Services/Marketing at 603-924-0062.



# RIVERMEAD APPLICATION AND WAITLIST AGREEMENT

**(I) (We) hereby make application for the Waitlist at RiverMead.**

**(I) (We) prefer the following Unit type(s):**

Choice 1 \_\_\_\_\_ Choice 2 \_\_\_\_\_

Choice 3 \_\_\_\_\_ Choice 4 \_\_\_\_\_

Anticipated move-in date: \_\_\_\_\_

This application is submitted with a non-refundable application fee of **\$250**, and a refundable Waitlist deposit of **\$2000 (for a total of \$2,250)**. When notified of an appropriate Unit (I) (We) intend, to pay the balance of the Entrance Fee or Entrance Fee deposit, which ever is appropriate, minus the refundable deposit paid, and execute a Residence and Care Agreement.

Please indicate title: (Mr., Mrs., Miss, Ms.)

Applicant (Name) \_\_\_\_\_

Second Person \_\_\_\_\_

Street Address \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

(Area Code) Telephone \_\_\_\_\_

(Area Code) Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

Email \_\_\_\_\_

Email \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**(I) (We) understand that submitting this application will place (my) (our) names(s) on the RiverMead Waitlist in chronological order. (I) (We) further accept the terms of the Waitlist Agreement shown on the next page.**

Applicant \_\_\_\_\_ Date: \_\_\_\_\_

Second Person \_\_\_\_\_ Date: \_\_\_\_\_



# ASSISTED LIVING WAITLIST AGREEMENT

1. In return for the payment of the refundable Waitlist deposit, and submitting a completed Confidential Data Application, applicants will be considered for admission in the order of their position on the List.
2. This application does not entitle applicants to admission to RiverMead, but only to priority consideration for admission. The decision to admit or not to admit an applicant is made by RiverMead in the exercise of its sole discretion. The applicant agrees to accept such decision as binding and final in all respects.
3. RiverMead will credit an applicant's Waitlist deposit against the Entrance Fee upon execution of the Residence and Care Agreement.
4. An applicant's rights under this agreement are personal to him or her, may not be assigned and shall not pass to his or her heirs or personal representatives. If application is made by two persons together, both are deemed to be included in the word "applicant" as used in this agreement.
5. Any notice to an applicant shall be sufficient if mailed to the address given or as applicant later advises RiverMead.
6. By signing this agreement now and submitting a Confidential Data Application (I) We agree to submit the balance of the 35% Entrance Fee deposit and sign the Residence and Care Agreement **within seven (7) days of notification.**\*

\* **Initial** \_\_\_\_\_

**Date:** \_\_\_\_\_

7. This Waitlist Agreement shall terminate if any one of the following occurs:
  - A. The applicant's application for admission is rejected by RiverMead.
  - B. RiverMead receives written notice of termination and a refund request.
  - C. The applicant executes a Residence and Care Agreement and pays the balance of the 35% Entrance Fee deposit, in which event all rights and obligations of the parties shall be governed by the Residence and Care Agreement.
  - D. The applicant fails to deliver a signed Residence and Care agreement and the balance of the 35% Entrance fee deposit within seven (7) days of notification.
8. **Within thirty (30) days** \* after receipt of the 35% Entrance Fee deposit and the signed Residence and Care Agreement, the balance of the Entrance Fee is required and the Monthly Service Fee will begin.

\* **Initial** \_\_\_\_\_

**Date:** \_\_\_\_\_





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# RIVERMEAD ASSISTED LIVING WAITLIST

## PLEASE SPECIFY YOUR UNIT CHOICES

Please Print Name:

\_\_\_\_\_  
Applicant #1

\_\_\_\_\_  
Second Person

(II) (We) prefer the following Unit type(s):

Choice 1 \_\_\_\_\_ Choice 2 \_\_\_\_\_

Choice 3 \_\_\_\_\_ Choice 4 \_\_\_\_\_

Anticipated move-in date: \_\_\_\_\_

Signatures:

Applicant #1 \_\_\_\_\_ Date: \_\_\_\_\_

Second Person \_\_\_\_\_ Date: \_\_\_\_\_



## Confidential Data Application

**Applicant One**

**Second Person**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Social Security # \_\_\_\_\_

Social Security # \_\_\_\_\_

**FINANCIAL DATA**

**MONTHLY INCOME**

**ASSETS:**

Applicant:

Second Person:

- 1. Residence \$ \_\_\_\_\_
- 2. Savings \$ \_\_\_\_\_
- 3. CD's \$ \_\_\_\_\_
- 4. Stocks \$ \_\_\_\_\_
- 5. Bonds \$ \_\_\_\_\_
- 6. Trusts \$ \_\_\_\_\_
- 7. Other Real Estate \$ \_\_\_\_\_
- 8. Mutual Funds \$ \_\_\_\_\_
- 9. Other \_\_\_\_\_ \$ \_\_\_\_\_
- 10. Other \_\_\_\_\_ \$ \_\_\_\_\_

- 11. Social Security \$ \_\_\_\_\_ \$ \_\_\_\_\_
- 12. Pension & Retirement \$ \_\_\_\_\_ \$ \_\_\_\_\_
- 13. Survivor's Pension % \$ \_\_\_\_\_ \$ \_\_\_\_\_
- 14. Annuities \$ \_\_\_\_\_ \$ \_\_\_\_\_
- 15. Other \$ \_\_\_\_\_ \$ \_\_\_\_\_

**COMBINED ASSETS** \$ \_\_\_\_\_

**TOTAL MONTHLY** \$ \_\_\_\_\_ \$ \_\_\_\_\_

**LIABILITIES**

- Mortgage \$ \_\_\_\_\_
- Other Debts \$ \_\_\_\_\_

**TOTAL COMBINED MONTHLY** \$ \_\_\_\_\_

**Are the above listed funds held jointly by both applicants?**

**Yes                      No**

\*Does the Pension amount increase with inflation? If so, describe adjustment process: \_\_\_\_\_

If no, please describe in detail, on a separate piece of paper, how the funds are divided.

**Circle the following responses that apply**

**Please see your policy binder for the following information**

	1st Person	2nd Person
Do you have long term care insurance?	Yes    No	Yes    No
Does it cover Assisted Living (enhanced housing)?	Yes    No	Yes    No
Does it cover Skilled Nursing?	Yes    No	Yes    No
What is the daily rate?	\$ _____	\$ _____
Do you plan on keeping your long term care insurance?	Yes    No	Yes    No

*All information subject to review and approval prior to occupancy.*

I HEREBY DECLARE THAT ALL STATEMENTS MADE HEREIN ARE TRUE AND COMPLETE ACCORDING TO MY BEST KNOWLEDGE AND BELIEF. IN WITNESS WHEREOF I HAVE SET MY HAND TO THIS APPLICATION THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Applicant



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# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MEDICAL PRACTICE/PHYSICIAN: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

I, \_\_\_\_\_, understand that my medical record contains confidential information. If I have discussed certain sensitive information with my personal physician or other provider, my medical record may also make reference to this information. Sensitive information includes alleged or actual drug/substance abuse; testing/treatment for AIDS or HIV; or treatment of psychiatric conditions. The above named medical practice has kept the information in my medical record in strict confidence. This information is being released at my request. I also understand that the above-named medical practice and/or physician cannot be held responsible for how this information is used once it is released.

I hereby authorize release of my medical information to:

Director of Health Services  
RiverMead Health Center  
300 RiverMead Road  
Peterborough, NH 03458

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Representative Signature



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# RESIDENT REPRESENTATIVE FORM

## *Information on Potential Resident's Representative*

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

PHONE: (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

RELATIONSHIP TO POTENTIAL RESIDENT: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

