Dear Potential, Future Resident

Thank you for inquiring about CARE'S Independent Living\ Residency Program. Our program is truly unique and magical! It has been specifically designed to meet the needs of recovering and retired RV'ers. However, it is also the most cost-efficient program in Texas or possibly, in the country.

Services provided by a professional staff are available Monday-Friday, excluding Holidays. By using Volunteers when staff is unavailable, your cost is minimized while providing you with personal assistance. Your site, shed, sewer, water, three meals daily, laundry, housekeeping and free local transportation is all included for a reasonable monthly fee.

To take advantage of this opportunity, please complete the attached application. We do require a recent primary care Physicians evaluation stating that you can and are able to live independently. Please contact Nurse Judy Burchfield for any questions. Email her at **carefn@escapees.com** or call **936-327-4256 x103**.

When we receive your completed application, Judy will contact you for a personal telephone interview. Based on a positive interview, the Admissions Committee will review your application to determine whether our program is a good fit for you and CARE.

Our founder Kay Peterson wanted a simple arrangement, no deposit nor long-term contracts; you pay one month in advance and leave by the month's end if our services aren't sufficient to your needs. This requires us to be responsive. We also require you to be a responsible tenant and a good neighbor to continue your stay here at CARE.

Please call or contact us if you have any questions and or concerns about our services, benefits, costs, or requirements.

Sincerely,

Russ Johnson

Executive Director

carefd@escapees.com

Resident Application

Name, First_____ M Int. ___ Last_____** Esc. No. _____

Street_____ City _____ State_____ Zip _____

Cell _____ Home _____ Work/Other _____

Date of Birth _____ Social Security # _____ Gender: Male [ ] Female [ ]

Number in CARE (if accepted) ____ Preferred arrival date: _____ Years that you lived in an RV: _____

CARE requires Residents to have an RV with holding tanks for black, gray, and fresh water, normally 40 feet in length or less, and in good repair. What is yours? **Motorhome** [ ] **Travel Trailer** [ ] **Fifth Wheel** [ ] **Year**: _____

Make: _____ Model: _____ Length: ____ No. of Slides: ____Condition: _____

Explain any RV defects or deficiencies: _____
Do plan to Buy: **Yes or No** If you expect to buy, BE CAUTIOUS about Park Models, some don't have holding tanks.

Do you have pets? **YES or NO** **CARE only allows small dogs under 50 lbs.** Initial that you agree: _____
CARE requires a current copy of your cat or dog's rabies vaccination. Review our attached Resident Guide!

What do you expect from our Independent Living Program? _____

_____

Date last seen by a doctor: _____Reason: _____

Doctor's Name: _____ Phone: _____Fax: _____

Address: _____

CARE recommends Residents obtain the care of a local physician as soon as possible after arriving here in CARE! Otherwise, you will be dependent on a hospital emergency room or an Urgent Care when it is open.

Food Allergies _____ Drug Allergies _____

Visual Impairment _____ Hearing Impairment _____

In the next several months, are you expecting to: Get Better [ ] Stay the Same [ ] Worsen [ ] ? Why_____

** CARE adjoins an Escapees RV Club Park; we expect Residents to become a member of the RV Club (about $50/yr.) to be able to use their facilities as part of our program. Escapees' members have donated 90% of our building cost.

Signature: _____ Date: _____

Potential Resident Cash Flow Assessment

Name, First_____ M Int. ___ Last_____ ** Esc. No. _____

Street_____ City _____ State_____ Zip _____

Cell _____ Home _____ Work/Other _____

1ST Email _____ 2ND Email _____

All information is kept confidential and cash flow statements must be updated each January, if requested!

	1ST Resident Monthly Income	2nd Resident Monthly Income	TOTAL
Pensions:	$_____	_____	_____
Social Security:	$_____	_____	_____
Dividends/Interest:	$_____	_____	_____
Savings:	$_____	_____	_____
C.D.s:	$_____	_____	_____
Other Assets (list):	$_____	_____	_____
_____	$_____	_____	_____
Monthly Expenses			
Mortgage:	$_____	_____	_____
RV note:	$_____	_____	_____
Auto note:	$_____	_____	_____
Vehicle insurance:	$_____	_____	_____
Medical insurance:	$_____	_____	_____
Credit card:	$_____	_____	_____
Medications:	$_____	_____	_____
Hospital/medical bills:	$_____	_____	_____
Other (list):	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____

Also, to protect existing Residents and our Day Activity and Health Services Individuals, we must (by Law) require all applicants to authorize our staff to do a criminal history background check on all their names, including maiden and aliases you have used in the past. Please list all other names that you may have used in the past:

By signing below, you are attesting that the information above is true and correct to the best of your knowledge and you are authorizing us to perform a criminal background check.

Signature: _____ Date: _____

PHYSICIAN'S EVALUATION

APPLICANT: Please fill out this section with your information, ***printing your Physician's Name*** & give it to him/her!

Name, First_____ M Int. ___ Last_____ DOB _____

Street_____ City _____ State_____ Zip _____

Home _____ Cell _____ Social Security # _____

Please Print

PHYSICIAN'S Name _____

Dear Physician, please fill out and answer questions pertinent to the applicant listed below. They are applying to our Independent Living program which will require them to walk outside to a separate dining hall. We are in Livingston, in Deep East Texas. For any questions, please contact our Nurse, Judy Burchfield by phone, preferably or secondarily by email. We are open 9am to 5pm (central time), Monday to Friday.

Work phone **936-327-4256** or Cell _____ or Email **carefn@escapees.com**

Please print out and attach an **UPDATED MEDICATION LIST!**

CIRCLE THE APPROPRIATE ANSWER!

Does this Person require a Caregiver? No Yes, If Yes, Is there a Mate capable of such care? No Yes

Can this Person self-administer medications? Yes No, If No, Is there a Mate capable of such care? No Yes

Are they capable of Independent Living? Yes No, if No, skip the following and please sign, with comments!

For persons capable of living independently (or having a Mate to assist them); what do you suggest for Exercise?

Sit & Be Fit: Yes No Exercise group: Yes No Weight Bearing: Yes No

Treadmill: Yes No Stationary Bike: Yes No

Give brief description of physical/mental condition & Limitations:

_____

Food Allergies _____ Drug Allergies _____

Visual Impairment _____ Hearing Impairment _____

Physician's signature: _____ Date: _____

Physician's License No/NPI: _____ State: _____

Address: _____

Office: _____ Cell: _____ Alternate: _____

Please fax or mail **Attn: Facility Nurse, Fax: 936-327-2368** or mail to **155 Care Center Dr., Livingston, TX 77351**