



INSTRUCTIONS TO SUBMIT

1. Download the form to your computer
2. Completely answer the questions
3. Save, print and mail with your \$1,000 check (payable to Well-Spring) to Well-Spring, 4100 Well Spring Dr., Greensboro, NC 27410
Thank you!

AGREEMENT TO JOIN THE WAIT LIST

This Agreement is made this _____ day of _____, 20____, between Well-Spring, A Life Plan Community, a North Carolina non-profit corporation (the "Corporation"), and _____ (the "Future Resident").

Introduction

Whereas, the Corporation owns and operates a Continuing Care Retirement Community in Guilford County, North Carolina ("Well-Spring"); and

Agreement

I. Living Accommodation Type

The Future Resident prefers to occupy an _____ or _____ or _____ living unit floor plan. In order to secure a place on the waiting list, the Future Resident agrees to make a deposit with the signing of this Agreement of \$1,000 (one thousand dollars).

II. Notification

The Future Resident has indicated a desire to enter Well-Spring, Well-Spring agrees to notify the Future Resident when the requested floor plan becomes available and there are no other Future Residents ahead of the Future Resident on the wait list. Within five (5) calendar days after notification, the Future Resident must accept or reject the offer of the available residence. If the offer is accepted, the Future Resident agrees to make a second deposit which, along with the initial deposit, will equal 10% of the then current Entry Fee and sign the Reservation Agreement. If the offer is rejected by the Future Resident, the Future Resident will remain on the wait list in the current position.

III. Balance of Payment and Monthly Service Fee

After final acceptance for residency into Well-Spring, the Future Resident agrees to sign the Residence and Care Agreement. Sixty (60) days after signing the Residence and Care Agreement the Future Resident agrees to pay the balance of the Entry Fee and begin paying the Monthly Service Fee.

IV. Deposits

Any deposits received by Well-Spring under this Agreement will be placed in a non-interest-bearing account on behalf of the Future Resident. If the Future Residents does not comply with the provisions as outlined above, all monies deposited with Well-Spring, less a non-refundable administrative fee of \$250 (two hundred and fifty dollars) will be refunded to the Future Resident within seven business days.

Your signature(s) indicate(s) that you understand and accept the terms stated in this Agreement.

Signature of Future Resident Date

Signature of Co-Future Resident Date

Signature of Well-Spring Representative Date

Year to be contacted: _____



CONFIDENTIAL FINANCIAL PROFILE

The following information is requested to assure the Board of Well-Spring that your financial resources will be adequate to fulfill your responsibilities to Well-Spring. The information supplied is strictly confidential. A more detailed summary may be requested before signing a reservation agreement.

NAME OF FUTURE RESIDENT: _____

NAME OF CO-FUTURE RESIDENT: _____

REGULAR MONTHLY INCOME

| | RESIDENT | CO-RESIDENT |
|-----------------|----------|-------------|
| Social Security | \$ | \$ |
| Pension | \$ | \$ |
| Other | \$ | \$ |
| Total | \$ | \$ |

ASSETS (Net of Debt) (Report joint holdings in one column only)

| | RESIDENT | CO-RESIDENT |
|-----------------------------|----------|-------------|
| Cash (Savings & Checking) | \$ | \$ |
| Investments | \$ | \$ |
| House (Equity in Residence) | \$ | \$ |
| Other | \$ | \$ |
| Total | \$ | \$ |

Long-Term Care Insurance Policy in effect? Yes No

If yes, please provide a copy of the Declaration Page.

I/we hereby declare that all statements made herein are true according to my/out best knowledge and belief. In witness whereof, I/we have hereunto set my/our hand(s) to this application on _____.
date (mm/dd/yyyy)

Signature of Future Resident: _____

Date of Birth: _____

Signature of Co-Future Resident: _____

Date of Birth: _____



Authorization for Release of Medical Information

Name: _____ Birth Date: _____

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____

PRIMARY CARE PHYSICIAN: _____

PHONE #: _____ FAX #: _____

Please list any other physicians or specialists you see:

| Name | Phone | Specialty |
|-------|-------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list all others on a separate sheet

Current information about your health will be requested from your physician. If you have not seen your physician within the past year for a comprehensive physical examination, the physician's office should contact you to schedule and appointment, which will be at your expense, in order that the required physician's medical forms may be completed.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician who has information about my medical condition or my past medical history to furnish such information to Well-Spring, A Life Plan Community for the purposes of evaluating my health any physical condition for acceptance into Well-Spring.

Signature of Future Resident

Date