



**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