

**Application Form #3**  
**Friendsview Retirement Community**
**FINANCIAL STATEMENT**

This Financial Statement need only reflect a guarantee that the applicant's financial situation provides for the terms of the Residency Agreement and for anticipated personal financial needs.

**All information contained herein will be held in strict confidence.**

A. Please report your (joint) monthly benefits as follows:

|  |          |
|--|----------|
| Applicant A:   | Monthly  |
| Social Security Payment  | \$ _____ |
| Pension and/or Retirement Income (do <u>not</u> include distributions from Retirement Funds listed below,) | \$ _____ |
| Other Monthly Income – <u>not</u> related to assets listed below:  | \$ _____ |
| Description _____  |          |
| Applicant A Total Monthly Income   | _____    |

|  |          |
|--|----------|
| Applicant B:   | Monthly  |
| Social Security Payment  | \$ _____ |
| Pension and/or Retirement Income (do <u>not</u> include distributions from Retirement Funds listed below,) | \$ _____ |
| Other Monthly Income – <u>not</u> related to assets listed below:  | \$ _____ |
| Description _____  |          |
| Applicant B Total Monthly Income   | _____    |

B. Please report your assets below:

|   |                 |
|---|-----------------|
| Present value of stocks and/or bonds  | \$ _____        |
| Retirement funds, IRA, (specify if <b>not</b> included in the monthly listed above) | \$ _____        |
| Present market value of real estate   | \$ _____        |
| Cash savings, certificates of deposit, etc  | \$ _____        |
| Other assets: auto, RV, etc.  | \$ _____        |
| <b>Total Assets</b>   | <b>\$ _____</b> |

C. Please report any debt below:

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D. Please provide on a separate sheet of paper an estimate of your personal monthly expenses.

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In case an emergency arises to the extent that you are unable to continue paying all of your monthly care fee, will your family or other person offer financial assistance?

Yes ( ) No ( ) Please explain \_\_\_\_\_

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Do you carry life insurance? Yes ( ) No ( ) If so, please list:

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| Company | Amount | Beneficiary |
|---------|--------|-------------|
|---------|--------|-------------|

Do you carry hospital and medical insurance other than Medicare? Yes ( ) No ( )  
If so, with which company? \_\_\_\_\_

What is your Medicare number? (nine digits and a letter) \_\_\_\_\_

Do you have a will? Yes ( ) No ( )

Who will be responsible for your financial matters in the event you are unable?

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Name of power of attorney: (Upon approval a copy of POA form is required)

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

Address: \_\_\_\_\_

Street

City

State

Zip

I hereby affirm that the preceding statements are true and correct as known by me, and are made for the purpose of gaining residency at Friendsview Retirement Community. If accepted, I pledge not to consign or diminish my financial resources necessary to execute my obligations to Friendsview Retirement Community.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ D.O.B. \_\_\_\_\_