Table of Contents/Checklist for Admissions

Rooming, Inc Admissions Packet

Po Box 5551 Scottsdale AZ 85261

602-348-2174
Roominginc@hotmail.com www.10greatestcompanies.com

ROOMING, INC

PART I: APPLICANT'S INFORMATION

Applicant's Social Security Number: _____

Applicant's Medical Assistance Number: _____

____Federal ___State Start date: _____/_____/_____ End date: _____/_____/_____

Last_____First_____M.I_____

Applicant's Permanent Mailing Address:
_____
P. O. Box No._____ Apt. No._____ City
State_____ Zip Code_____

Applicant's Telephone Number: (_____)_____

Signature of Person Completing Application_____Date: _____

Applicant's Date of Birth: Month: _____ Day:_____Year:_____

Applicant's sex: _____Male _____female

Applicant's Race: _____ (1) Black_____ (2) White _____ (3)
Native American_____ (4) Asian _____ (5) Other

Applicant's Marital Status: ____ (1) Single ____ (2) Married ____ (3) Divorced ____
(4) Widowed _____

Applicant's Mobility: ___ (1) Walks independently ___ (2) Walks with supportive devices ___
(3) Walks unaided with difficulty ___ (4) In wheelchair operated by self ___ (5) In wheelchair &
needs help ___ (6) No mobility

Applicant's ability to communicate:

___ (1) Speaks and can be understood ___ (2) Speaks and is difficult to understand ___ (3) Uses gestures ___ (4) Uses Sign Language ___ (5) Uses communication board or device ___ (6) None

Applicant's skill in activities of daily living:

Completely Independent_____

Needs assistance with:
A. Eating…….. _____
B Dressing…… _____

C. Bathing……. _____
D. Toileting……... _____
E. Hygiene…… _____
F. Transfers in/out of bed….. _____

Applicant's need for supervision:

___ (1) No supervision ___ (2) Occasional monitoring ___ (3) Minimal daily supervision
___ (4) Substantial daily supervision ___ (5) Continuous supervision during waking hours
___ (6) Continuous 24 hours per day supervision ___ (7) Not sure

Applicant's functioning level:

___ (0) No entry ___ (1) Mild ___ (2) Moderate ___ (3) Severe ___ (4) Profound
___ (5) Unknown

PART II: CAREGIVER/GUARDIAN/NEXT-OF-KIN INFORMATION

The primary caregiver is the person responsible for the applicant's daily care. If the applicant is in a residential facility, put down the name of the contact person.

Primary caregiver's name: _____Last, First

Primary caregiver's permanent mailing address:

_____
_____

_____
City State Zip Code

Telephone: (_____) _____
Relationship to applicant: ____ (1) Parent ____ (2) Spouse ____ (3) Self ____ (4) Not related ____ (5) Public/Private Agency

NEXT-OF-KIN

If the next-of-kin is not the primary caregiver or the legal guardian appointed by the court, complete the following section:

Next-of-kin's name:_____

Next-of-kin's permanent mailing address: _____

P. O. Box No. Apt. No_____

City State Zip Code_____

Telephone: (_____) _____

Relationship to applicant: ____ (1) Parent ____ Self (2)____ (3) Spouse ____ (4) Other relative

(5) other_____

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BASIC SERVICES

A. To ensure a safe and healthful living environment for all residents the following basic services must be available. The services actually provided will be those the resident wants and those the resident needs, based on the individual's pre-admission appraisal, and the needs and services plan. Subsequent resident appraisals may result in the need for additional basic services.
B. Basic services at a minimum include:
(1) Continuous care and supervision;
(2) Observation for changes in physical, mental, emotional, and social functioning; and
(3) Notification to resident's family, physician, and other appropriate person/agency of Resident's needs.
(4) Lodging: ____ single room ____ double room
(5) Food Services: (**Provided by Nothing Butt**)
____ 1. Three nutritious meals daily and snacks.
____ 2. Special diets if prescribed by a doctor.
____ 3. Other meal services described as follows: _____
_____
(If additional space is needed, attach signed and dated sheet.)
(6) Helping gain access to supportive services as follows:
_____
_____
(If additional space is needed, attach signed and dated sheet.)
NOTE: "Responsible person" means that individual or individuals, including a relative, health care surrogate decision maker, or placement agency, which assist the resident in placement or assume varying degrees of responsibility for the resident's well-being.
(7) ____ Plan, arrange and/or provide for transportation to medical and dental appointments as follows (Provided by rideemtaxi):_____
_____
_____
(If additional space is needed, attach signed and dated sheet.)
(8) ____ A planned activity program including arrangement for utilization of available Community resources as follows: _____
_____
_____
(If additional space is needed, attach signed and dated sheet.)
(9) ____ Assistance with personal activities of daily living as follows:
____ eating,
____ grooming,
____ mobility tasks, and
____ other personal care needs: _____
_____
(If additional space is needed, attach signed and dated sheet.)
Additional basic services that the resident needs or wants, and that will be provided by the facility, include those checked below:
(10) ____ Hygiene items of general use, such as soap and toilet paper.

(11) ____ Laundering personal clothing.
(12) ____ Clean bed and bath linens weekly, or as often as needed.
(13) ____ Cleaning of resident's room
(14) ____ Comfortable and suitable bed and bedroom furniture.
(15) ____ Assistance in meeting necessary medical and dental needs as follows:
_____
(If additional space is needed, attach signed and dated sheet.)
(16) ____ Assistance with taking prescribed and over-the-counter medications in accordance with physician's instructions unless prohibited by law or regulations. (**Provided by Healing Star**)
(17) ____ Bedside care and tray service for minor temporary illnesses or recovery from surgery.
(18) ____ Maintenance or supervision of resident cash resources as follows:
_____
_____
(If additional space is needed, attach signed and dated sheet.)

SIGNATURES

The signature of the resident and/or responsible person indicates that he/she has read, or had read and explained to him/her. The form must be dated and signed, acknowledging the contents, by the resident and/or responsible person if any, and the licensee, or designated representative upon admission.

RESIDENT: _____ Date_____

RESIDENT'S RESPONSIBLE PERSON OR CONSERVATOR: (IF APPLICABLE)

_____ Date_____

LICENSEE/FACILITY REPRESENTATIVE:

_____ Date_____

Rooming, Inc.

Po Box 5551
Scottsdale AZ
85326
roominginc@hotmail.com

Healing Star

Po Box 5551
Scottsdale AZ
85326
healingstar@hotmail.com

Nothing Butt

Po Box 5551
Scottsdale AZ
85326
nothingbutt@hotmail.com

602-348-2174

www.10greatestcompanies.com

Consent for Emergency Medical Treatment-Needs assessed by Healing Star

Resident Name _____
Date of Birth _____
Address_____
_____
Street *City* *State* *Zip*
Telephone_____
Resident's Disability _____Date of Onset_____
Physician'sName_____
Address_____
Telephone _____
Preferred Medical Facility_____
Does Resident have any medical condition(s) requiring special precautions or treatments and any medications and dosage? □ Yes □ No If you answered "yes," please describe:
_____
_____
_____

In case of medical emergency, the undersigned authorizes Rooming Inc, acting through the person on staff who has actual care of the resident, to consent to medical, dental, and surgical treatment of the resident when the undersigned cannot be contacted. The undersigned represents to Rooming Inc, that he or she is the residents appointed emergency contact person and has been authorized by the resident to give consent to medical and dental care and surgical treatment of the resident. The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the resident, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent from the undersigned.

***PLEASE NOTE**

Although every effort will be made to avoid any type of accident or injury, **NO LIABILITY** can be accepted by Rooming Inc.

Yes, I _____give permission to **Rooming Inc/Healing Star** the authorization to my consent for medical /dental treatment. I understand that **NO LIABILITY** can be accepted by Rooming Inc/Healing Star in the event of any accident or injury which may occur.

_____ _____
Signature Resident Date

_____ _____
Signature of Undersigned Date

Resident Insurance Carrier/Medicare/Medical_____

Policy Number _____

Healing Star-Po Box 5551 Scottsdale AZ 85261 602-348-2174

healingstar@hotmail.com www.10greatestcompanies.com roominginc@hotmail.com

General Durable Power of Attorney

I, _____, a resident of _____ Social Security Number _____ designate _____, presently residing at _____, as my attorney in fact (referred to as "the Agent") on the following terms and conditions:

1) **Authority to Act**. The Agent is authorized to act for me under this Power of Attorney and shall exercise all powers in my best interests and for my welfare.

2) **Powers of Agent**. The Agent shall have the full power and authority to manage and conduct all of my affairs, and to exercise my legal rights and powers, including those rights and powers that I may acquire in the future, including the following:

   i) **Collect and Manage**. To collect, hold, maintain, improve, invest, lease, or otherwise manage any or all of my real or personal property or any interest therein;

   ii) **Buy and Sell**. To purchase, sell, mortgage, grant options, or otherwise deal in any way in any real property or personal property, tangible or intangible, or any interest therein, upon such terms as the Agent considers proper, including the power to buy United States Treasury Bonds that may be redeemed at par to pay federal estate tax and to sell or transfer Treasury securities;

   iii) **Borrow**. To borrow money, to execute promissory notes therefor, and to secure any obligation by mortgage or pledge.

   iv) **Business and Banking**. To conduct and participate in any kind of lawful business of any nature or kind, including the right to sign partnership agreements, continue, reorganize, merge, consolidate, recapitalize, close, liquidate, sell, or dissolve any business and to vote stock, including the exercise of any stock options and the carrying out of any buy sell agreement; to receive and endorse checks and other negotiable paper, deposit and withdraw funds (by check or withdrawal slips) that I now have on deposit or to which I may be entitled in the future in or from any bank, savings and loan, or other institution;

   v) **Tax Returns and Reports**. To prepare, sign, and file separate or joint income, gift, and other tax returns and other governmental reports and documents; to consent to any gift; to file any claim for tax refund; and to represent me in all matters before the Internal Revenue Service;

vi) **Safe Deposit Boxes**. To have access to any safety deposit box registered in my name alone or jointly with others, and to remove any property or papers located therein;

vii) **Proxy Rights**. To act as my agent or proxy for any stocks, bonds, shares, or other investments, rights, or interests I may now or hereafter hold;

viii) **Legal and Administrative Proceedings**. To engage in any administrative or legal proceedings or lawsuits in connection with any matter herein;

ix) **Transfers in Trust**. To transfer any interest I may have in property, whether real or personal, tangible or intangible, to the trustee of any trust that I have created for my benefit;

x) **Delegation of Authority**. To engage and dismiss agents, counsel, and employees, in connection with any matter, upon such terms as my agent determines;

xi) **Restrictions on Agent's Powers**. Regardless of the above statements, my agent (1) cannot execute a will, a codicil, or any will substitute on my behalf; (2) cannot change the beneficiary on any life insurance policy that I own; (3) cannot make gifts on my behalf; and (4) may not exercise any powers that would cause assets of mine to be considered taxable to my agent or to my agent's estate for purposes of any income, estate, or inheritance tax, and (5) cannot contravene any medical power of attorney I have executed whether prior or subsequent to the execution of this Power of Attorney.

3) **Durability**. This durable Power of Attorney shall be irrevocable until the trust corpus is surrendered by the trustees, shall not be affected by my death or disability except as provided by law, and shall continue in effect after the surrender of the trust corpus until my death or until revoked by me in writing.

4) **Reliance by Third Parties**. Third parties may rely upon the representations of the Agent as to all matters regarding powers granted to the Agent. No person who acts in reliance on the representations of the Agent or the authority granted under this Power of Attorney shall incur any liability to me or to my estate for permitting the Agent to exercise any power prior to actual knowledge that the Power of Attorney has been revoked or terminated by operation of law or otherwise.

5) **Indemnification of Agent**. No agent named or substituted in this power shall incur any liability to me for acting or refraining from acting under this power, except for such agent's own misconduct or negligence.

6) **Original Counterparts**. Photocopies of this signed Power of Attorney shall be treated as original counterparts.

7) **Revocation**. I hereby revoke any previous Power of Attorney that I may have given to deal with my property and affairs as set forth herein.

8) **Compensation**. The Agent shall be reimbursed for reasonable expenses incurred while acting as Agent and may receive reasonable compensation for acting as Agent.

9) **Substitute Agent**. If_____ is, at any time, unable or unwilling to act, I then appoint _____, presently residing at_____ as my Agent.

Dated: _____

_____
Resident Signature

Signed in the presence of:

_____
[WITNESS]

_____
[WITNESS]

Subscribed and sworn to before me on_____.

_____ Notary Public,
_____ My commission expires _____.
(County & State)

Rooming, Inc 602-348-2174 roominginc@hotmail.com
Po Box 5551
www.10greatestcompanies.com Scottsdale, AZ
85261

NOTICE OF PRIVACY PRACTICES ACKNLOWLEDGEMENT AND CONSENT

This notice of Privacy Practices tells you how we ROOMING, INC may use and share your health records.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights can be explained in more detail if need be.

I agree to allow Rooming Inc to share or use my health records.

Signature: _____ Date_____
(of Resident or Legal Representative)

Capacity of Legal Representative (if applicable) _____

Rooming, Inc
Po Box 5551

Scottsdale AZ
85261

602-348-2174

roominginc@hotmail.com
www.10greatestcompanies.com

IDENTIFICATION AND EMERGENCY INFORMATION

This information is required under the regulations of the Department to be maintained on every person admitted to Rooming Inc, to be readily available to the person in charge, but not accessible to unauthorized persons. All information must be kept current. (**PLEASE ATTACH ALL PHOTOS AT THE END OF THIS FORM**)

1. NAME OF RESIDENT (PHOTO NEEDED)
_____

2. RESPONSIBLE PERSON OR PLACEMENT AGENCY_____

3. NAME OF NEAREST RELATIVE (OPTIONAL) _____

4. DATE ADMITTED TO ROOMING INC_____

5. PHYSICIAN_____

6. MENTAL HEALTH PROVIDER, IF ANY_____

7. DENTIST_____

8. RELATIVE(S) _____

9. FRIEND(S) _____

10. AMBULATORY STATUS_____

11. RELIGIOUS PREFERENCE_____.

COMMENTS:
_____
_____

SIGNATURE OF RESIDENT
_____

SIGNATURE OF PERSON COMPLETING FORM _____

DATE_____

NAME AND ADDRESS OF CLERGYMAN OR RELIGIOUS ADVISOR, IF ANY_____
TELEPHONE_____

NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY_____
___
ADDRESS OF HOSPITAL TO BE TAKEN IN AN EMERGENCY_____
___

MEDICAL PLAN IDENTIFICATION NUMBER_____

DENTAL PLAN NUMBER (IF ANY)
_____

MEDICAL PLAN_____

NAME OF DENTAL PLAN (IF ANY)
_____

SOCIAL SECURITY NUMBER (PHOTO NEEDED)
_____

DATE OF BIRTH_____

AGE _____

SEX_____

NAME OF EMERGENCY CONTACT_____

RELATIONSHIP _____

ADDRESS
_____

TELEPHONE_____ **CELL #**_____

COMMENTS:
(IF ANY)_____

NAME AND PHONE NUMBER OF PERSON TO CONTACT, IF AUTHORIZED REPRESENTATIVE IS NOT AVAILABLE_____

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Weekly Medicine Chart-Healing Star

Use this form to help residents keep track of his or her medications.

How to Use your Weekly Medicine Record

Here's a handy record to help your residents keep track of what medicines to take every day, when to take them, and when he or she took them.

Write name and date, starting on Sunday, at the top of the record.

Each numbered row is for one medicine. Take the name and dosage of each medicine and from the label on each container and write them under the first column.

In the second column, write the size, shape and color of the pill. For example: Small, round, white pill.

In the third column, write when to take the medicine. For example: Before breakfast.

When your resident takes a medicine, place an "X" in the column for the day of the week. If your resident takes a medicine more than once a day, mark it each time.

Name: _____
Week of: _____

Name & Dosage of Medicine	Size, Shape, Color of the Pill	When to take Medicine	Sun	Mon	Tue	Wed	Thu	Fri	Sat

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healingstar@hotmail.com

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Medication Intake Form
Healing Star

Please print or type:

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: (_____)_____ Male Female Marital Status: _____

Social Security Number: _____ Birth Date: ____/_____/_____

CURRENT MEDICATIONS:

Medication	Dose	Route	Schedule	How Long?

Any PRN medications and for what target symptoms:

Medication	Dose	Route	How Often	For

Physician Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (_____)_____

Signature _____ Date _____

Names of other supporting professionals: _____

_____

Name Telephone Number

_____

Name Telephone Number

ADDITIONAL NOTES AND COMMENTS:

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Po Box 5551
Scottsdale AZ
85261
roominginc@hotmail.com

Healing Star
Po Box 5551
Scottsdale AZ
85261
healingstar@hotmail.com

602-348-2174

www.10greatestcompanies.com

Weekly Food Intake- Healing Star

Week of: _____

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Supplements_____

Breakfast_____

Snack_____

Lunch_____

Snack_____

Dinner_____

Notes:_____
_____
_____
_____
_____
_____
_____

***Please note: We will try and accommodate any resident who has a special diet as best as we can**

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Scottsdale AZ

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roominginc@hotmail.com healingstar@hotmail.com

PROPERTY INVENTORY FORM

Date_____

Resident Name_____

Reason for Inventory:
Admit_____
Move Out____

Other Property List and quantity of each item

Arts/Crafts/Paper	Electrical Power Bar (1)	Photo Album (1)
Athletic Shoes (1)	Emery Boards**(2)	Picture Frame (8"x10") (1)
Athletic Supporters (1-2)	Fingernail Clippers (1)	Plastic Coffee Cup (1)
	Footwear (1) [if no athletic shoes]	Plastic Drinking Cup (1)
Baseball/Stocking Cap (1-2)	Gym/Walking Shorts (1-2)	Playing Cards (1 Set)
Bathrobe* (1)		Postage Stamps (20)
Personal Jeans (5)		Ring (1 plain wedding band—no stones)
Personal Shirts (5)		Sewing Kit (1)
Hair Clip**(1)		
Hair Rollers**(20)	Shower Shoes (1)	
Bowl with Lid (1)	Headsets (2)	Soap Dish (1)
Bras** (7)	Ice Bucket (1)	Socks (7)
Briefs/Boxer Shorts (7)	Inmate ID (1)	Spoon (1)
Brush/Comb/Pick (1-2)	Legal Material (1 cubic foot)	Sweat suits (1-2)
	Makeup Bag** (1)	T-Shirt, State Issue (1)
Combination Padlocks (2)	Nicotine Patches (1 Series)	T-Shirt, Commemorative (1)

Baseball/Stocking Cap (1-2) Gym/Walking Shorts (1-2) Playing Cards

Baseball/Stocking Cap (1-2)

Gym/Walking Shorts (1-2)

Playing Cards (1 Set)

Bathrobe* (1)

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RECORD OF RESIDENT'S SAFEGUARDED CASH RESOURCES

Resident: Your signature below indicates you have received the following amount of money from the facility on the date indicated.

Facilities that handle resident's cash resources must maintain accurate records of all money received and disbursed.

INSTRUCTIONS:
1) The date of the transaction shall be noted under Date.
2) Use a separate line for each transaction.
3) Supporting receipts for purchases shall be filed in order of dates of purchases.
4) The resident's (or resident's representative) signature on this form may serve as a receipt for cash distribution to the resident.
5) The facility representative's signature is necessary to be able to verify a cash transaction.

NAME OF RESIDENT_____
DATE_____
DESCRIPTION AMOUNT_____
RECEIVED_____
AMOUNT SPENT OR WITHDRAWN_____
BALANCE_____

SIGNATURE FOR CASH TRANSACTIONS_____

FACILITY REPRESENTATIVE RESIDENT
OR REPRESENTATIVE_____

DATE_____

Rooming, Inc.
Po Box 5551
Scottsdale AZ

Cash your way
Po Box 5551
Scottsdale AZ

602-348-2174

www.10greatestcompanies.com

85261 85261
roominginc@hotmail.com cashyourway@hotmail.com

ATTENDANT CARE/HOUSEKEEPING

RESIDENT NAME _____ DATE_____

HOUSEKEEPING	**FREQUENCY ESTIMATE**
Kitchen	
Floor	
Counter tops	
Outside cabinets	
Wash dishes Hand Dishwasher	
Dry dishes Hand Dishwasher	
Store dishes	
Clean refrigerator	
Other *(Specify)*	
Living room/Dining room Floor	
Dust *(e.g., tables, furniture)*	
Other *(Specify)*	
Miscellaneous Duties	
Take out garbage *(Curb side only)*	
Wash laundry Hand Machine	
Dry laundry Hand Machine	
Fold laundry	
Shopping for food and household	
Other *(Specify)*	

COMMENTS/SPECIALIZED INSTRUCTIONS *(e.g., list cleaning methods - vacuum, sweep, mop, scour with cleanser, disinfect, wipe down with cleaner,*

*etc:*_____
_____
_____

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FACILITY VISITING POLICY
Guest information form

A. Rooming, Inc encourages family visits and communication. Regular family involvement with the resident is encouraged. We want to provide the opportunity for family participation in facility activities.

B. Facility visiting hours are _____ .

Our policy concerning visits is:

_____
_____

C. Our policy concerning other communication with residents is:

_____
_____
_____

D. When receiving visitors please take down:

Name_____
E-mail address_____
License plate #_____
Phone Number_____

Rooming Inc	Sharing a Room	Protecting Rooms
Po Box 5551	Po Box 5551	Po Box 5551
Scottsdale AZ	Scottsdale AZ	Scottsdale
85261	85261	85261

roominginc@hotmail.com sharearoom@hotmail.com protectingrooms@hotmail.com

www.10greatestcompanies.com

602-348-2174

HOUSE RULES

A. The house rules must be for the purpose of making it possible for residents to live together. When referring to a resident's obligation to observe facility rules, you must ensure the rules are reasonable, and inform the resident of the procedure for suggesting rule changes.

B. The following house rules must be observed:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(If additional space is needed, attach signed and dated sheet.)

C. The procedure for suggesting rule changes is as follows:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Rooming, Inc
Po Box 5551
Scottsdale AZ
85261
roominginc@hotmail.com

Share a Room
Po Box 5551
Scottsdale AZ
85261
sharearoom@hotmail.com

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ROOMING, INC

Po Box 5551 Scottsdale AZ 85261-5551

FIRST PAYMENT SERVICES

Auto Pay Application

6/2/2008

PLEASE CIRLCE:

NEW UPGRADE OR REPLACMENT IN ADDITION TO PREVIOUS CHANGE TO BANK ACCOUNT

Tenant Name:_____ Telephone_____

Address: _____

City/State/Zip: _____

Bank Name: _____

I authorize withdrawals from the designated account, with a start date of: _____, in the amount of: _____, until I cancel said withdrawals.

Any additional arrangements, such as different amount for first payment or payments other that monthly:

I understand that it is my responsibility to assure that adequate funds are in the designated account on the due-date(s). I also understand that I am in full control of my payments. If at any time I decide to discontinue or alter this payment method, I need only notify Rooming, Inc. a minimum of five working days before the payment date.

ATTACH VOIDED CHECK

(Be sure numbers along bottom of check are clear and readable)

_____ _____

Signature as used when signing checks Date

Rooming Program

Month-to-Month Lease Agreement for Furnished Room

Date: _____, 20_____

RECEIPT IS ACKNOWLEGED by Share A Room, hereinafter referred to as “Management”

From_____, hereinafter referred to as “Resident”, the sum of $_____deposit, and the sum of $_____ for the first month’s rent of the premises, owned by Management, and located at 1602 W. McDowell Rd, Phoenix, AZ 85007, hereinafter referred to as “the premises”. Management agrees to rent premises to resident on a month-to-month basis at a rental basis of $_____per month, payable in advance on the _____ day of each month.

In consideration hereof, and the use or occupancy of the said premises, resident agrees:

1. To maintain the premises in a clean, orderly and law-abiding manner and to keep the yards thereof free of weeds, debris, and/or material that may become unsightly or a detriment to the appearance of said premises. Management shall have the right to enter and inspect said premises at any reasonable times.
2. That no alterations or redecorating of any kind to the dwelling shall be make without the prior written consent of Management.
3. To pay the cost of all repairs for any damage done by resident to said premises which Management may consider necessary.
4. That no birds, animals, or other pets shall be kept in the premises.
5. Not to let or sublet the whole or any part of the premises to anyone for any purpose whatever without prior written permission from Management.
6. To give seven (7) days notice to Management prior to vacation the premises and to permit prospective tenants the opportunity of reasonable inspection.
7. To clean the premises upon vacating and restore the premises to the same condition they are now in, reasonable wear and tear and damage by the elements excepted.
8. That the violation of any of the covenants of the agreement or the non-payment of any rents due and unpaid shale be sufficient for eviction from said premises upon two (2) days written notice.

9. To pay all costs owing including rent, removal of furnishings or other items belonging to Management, and repairs of damages to premises.
10. All amounts due will be paid prior to move-out. Any amounts still owed will be deducted from Resident's deposit.
11. All rents shall be paid at the location designated by Management
12. Resident has read, acknowledged and signed the "House Rules". (Initials_____)
13. Proof of social security income

No waiver will be made by Management at any time of any of the terms of this agreement. Resident acknowledges receipt of a copy of this agreement.

Resident Name (printed) _____
Residents Signature_____
Case Worker Name (printed) _____
Contact Phone_____
Office Phone_____ Extension_____
Resident's SSAN_____ Age_____Date of Birth _____
Received by (Printed Name) _____
Signed by_____

Mail Payment To:

Rooming, Inc.
Po Box 5551
Scottsdale, AZ 85261

*For quick payment go to any Bank of America use account # 4370026228
*For quick payment go to any Washington Mutual use account # 3160351925

For nearest Bank of America call-
For nearest Washington Mutual call-

For directions use www.mapquest.com
If you need transportation please go to rideemtaxi@hotmail.com

QUESTIONS? PLEASE CALL:

Contact: Mr. Elijah Brown
ID#_____
Cell #: 602-348-2174
Business #: 602-274-0560
Email: elijahbrown43@msn.com
Email: roominginc@hotmail.com
www.10greatestcompanies.com

Agent

This document must be notarized

Rooming, Inc Po Box 5551 Scottsdale, AZ 85261-5551 (602) 348-2174
www.10greatestcompanies.com, roominginc@hotmail.com

FIRST PAYMENT SERVICES

Auto Pay Application

6/2/2008

PLEASE CIRLCE:

NEW UPGRADE OR REPLACMENT IN ADDITION TO PREVIOUS CHANGE TO BANK ACCOUNT

Tenant Name:_____ Telephone_____

Address: _____

City/State/Zip: _____

Bank Name: _____

I authorize withdrawals from the designated account, with a start date of: _____, in the amount of: _____, until I cancel said withdrawals.

Any additional arrangements, such as different amount for first payment or payments other that monthly:

I understand that it is my responsibility to assure that adequate funds are in the designated account on the due-date(s). I also understand that I am in full control of my payments. If at any time I decide to discontinue or alter this payment method, I need only notify Rooming, Inc. a minimum of five working days before the payment date.

ATTACH VOIDED CHECK

(Be sure numbers along bottom of check are clear and readable)

_____ _____

Signature as used when signing checks Date

Rooming Program

Week-to-Week Lease Agreement for Furnished Room

Date: _____, 20_____

RECEIPT IS ACKNOWLEGED by Share A Room, hereinafter referred to as “Management”

From_____, hereinafter referred to as “Resident”, the sum of $_____deposit, and the sum of $_____ for the first month’s rent of the premises, owned by Management, and located at 1602 W. McDowell Rd, Phoenix, AZ 85007, hereinafter referred to as “the premises”. Management agrees to rent premises to resident on a week-to-week basis at a rental basis of $_____per month, payable in advance on the _____ day of each month.

In consideration hereof, and the use or occupancy of the said premises, resident agrees:

1. To maintain the premises in a clean, orderly and law-abiding manner and to keep the yards thereof free of weeds, debris, and/or material that may become unsightly or a detriment to the appearance of said premises. Management shall have the right to enter and inspect said premises at any reasonable times.
2. That no alterations or redecorating of any kind to the dwelling shall be make without the prior written consent of Management.
3. To pay the cost of all repairs for any damage done by resident to said premises which Management may consider necessary.
4. That no birds, animals, or other pets shall be kept in the premises.
5. Not to let or sublet the whole or any part of the premises to anyone for any purpose whatever without prior written permission from Management.
6. To give seven (7) days notice to Management prior to vacation the premises and to permit prospective tenants the opportunity of reasonable inspection.
7. To clean the premises upon vacating and restore the premises to the same condition they are now in, reasonable wear and tear and damage by the elements excepted.
8. That the violation of any of the covenants of the agreement or the non-payment of any rents due and unpaid shale be sufficient for eviction from said premises upon two (2) days written notice.

9. To pay all costs owing including rent, removal of furnishings or other items belonging to Management, and repairs of damages to premises.
10. All amounts due will be paid prior to move-out. Any amounts still owed will be deducted from Resident's deposit.
11. All rents shall be paid at the location designated by Management
12. Resident has read, acknowledged and signed the "House Rules". (Initials_____)
13. Proof of social security income

No waiver will be made by Management at any time of any of the terms of this agreement. Resident acknowledges receipt of a copy of this agreement.

Resident Name (printed) _____
Residents Signature_____
Case Worker Name (printed) _____
Contact Phone_____
Office Phone_____ Extension_____
Resident's SSAN_____ Age_____Date of Birth _____
Received by (Printed Name) _____
Signed by_____

Mail Payment To:

Rooming, Inc.
Po Box 5551
Scottsdale, AZ 85261

*For quick payment go to any ***Bank of America*** use account # 4370026228
*For quick payment go to any ***Washington Mutual*** use account # 3160351925

For nearest Bank of America call- 1-800-432-1000
For nearest Washington Mutual call- 1-800-788-7000

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Email: roominginc@hotmail.com
www.10greatestcompanies.com

Agent

This document must be notarized

Rooming, Inc

Payment Receipt

Date:_____
Time:_____
Business# :_____
Fax #:_____
E-mail address: roominginc@hotmail.com

Resident name:_____

House Address:_____

Unit #_____
Room # _____

Date_____

(Cash)_____
(Cashier C.)_____
(Money O)_____
(Amount)$_____

Your next payment due on_____

Please pay on time to avoid the late charge of $10.00 per day

Resident Signature:_____

Received by:_____
ACCEPTED WITH FULL WEEKLY RENT