Application for Residency

Date Application Mailed _____

Date Application Received _____

Application for Residence/Admission to the Senior Living Community an Eastern Star Home

A. Personal Information

Applicant's Name:_____Maiden Name: _____

Address: _____

Home Phone:_____ Birth date:_____/___/_____

Age: _____ Gender: _____ Social Security:_____/_____/_____

Who shall we contact about this application?

Name(s), address, telephone and email of nearest relative/responsible individual to assist you with this application process, and their legal capacity.

Name_____Relationship _____

Address _____

Email _____

Telephone: Cell _____ Home _____ Work _____

Legal capacity, if any._____(please attach copy of legal document)

B. Medical Information

Are you currently in a hospital, nursing home, or rehab center? Yes_____No _____

Name and address of primary care physician: _____

_____

Name and address of other physician(s) and reason for this services: _____

_____

Name and address of other physician(s) and reason for their services: _____

_____

How do you normally get to your medical appointments? _____

_____

Please list your diagnosis/ medical issues: _____

_____

Do you need assistance with personal care? If yes, please explain what assistance you need: _____

_____

_____

Upon acceptance into the program, a physical examination must be completed within 90 days.

SUPPLEMENTAL INFORMATION/REFERRAL REQUIREMENTS

The Senior Living Community an Eastern Star Home provides the very best for our residents in all aspects. A physician's referral is necessary before any final decisions can be made. The referral forms are attached towards the end of this application. Please see the FORMS page for specific information.

C. General Questions

Do you have a legally binding POA (Power Of Attorney)? Yes _____ No _____
(Please provide copy of document with application)

Are you living: Independently ____ With Spouse/Partner____ With Family ___Other _____

Do you know anyone else that lives here or has lived here in the past?_____

Have you been convicted of any felonies? Yes_____ No_____

Are you a United States citizen? Yes _____ No _____

Are you or your spouse a U.S. Veteran? Yes _____ No _____

If yes, did you serve during wartime? Yes _____ No _____

Are you legally capable of entering a lease agreement? Yes _____ No _____

D. Financial Information: Income

(All sources of regularly received money must be listed)

Social Security **Gross** Monthly Amount $ _____
(this includes medical insurance benefit)

Pension Gross Monthly Income $ _____

VA Benefits Gross Monthly Amount $ _____

SSI Benefits Gross Monthly Amount $ _____

Interest Income Prior Year/12 Months $ _____

Other Monthly Income
(List on back if more than one item, then put total here) $ _____

Total Gross Monthly Income **$_____**

E. Financial Information: Assets

Checking Accounts

Bank/Location_____Balance $ _____

Bank/Location_____Balance $ _____

Savings Accounts

Bank/Location_____Balance $ _____

Bank/Location_____Balance $ _____

Certificates of Deposits, etc.

Bank/Location_____Balance $ _____

Trust Accounts

Bank/Location_____Balance $ _____

Stocks, Bonds (specify)

Bank/Location_____Balance $ _____

Other _____

Real Estate/Property

Do you currently own any property? Yes_____No_____

If yes, type of property_____Location of property _____

Appraised market value $_____

Have you sold or disposed of any assets in the last five years? Yes_____No _____

If yes, list type of assets (e.g. money/land/house)_____Date of transaction_____

Market value when sold/disposed $_____ Amount sold/disposed for $_____

Note: Please attach an additional sheet of information if it will help explain your financial situation.

F. Insurances, Government Program Enrollments and Medical Coverage

(Complete where appropriate and list any costs associated with each item.)

Medi-Cal: State_____#_____ Medicare #_____

Supplemental Health Insurance_____Monthly amount $_____

Name, address and policy # of supplemental and/or long term care insurance company:

_____

G. References

Current Landlord (name, address, telephone #) _____

_____

Previous Landlords

1. Name, address, telephone

_____

_____

_____

2. Name, address, telephone

_____

_____

_____

Credit references (name, address, telephone)

1. _____

2. _____

3. _____

Personal references (name, address, telephone)

1. _____

2. _____

Forms

GENERAL CERTIFICATION

I understand that all payments owed by the applicant tenant must be made prior to occupancy. I certify that The Senior Living Community an Eastern Star Homes will be my primary residence.

I understand that tenant selection is based on a number of factors, primarily on the assessment of SLC's Resident Services Assessment Team to estimate – in their best judgment – my ability to be successful in and appropriate for the assisted living environment. Further, I understand that my application can be rejected based on, but not limited to, poor credit or personal references, police records indicating unacceptable or criminal behavior, and medical records indicating violent or self abuse behaviors. I also understand that if my medical condition requires an extended stay in a skilled nursing facility, if my behavior becomes inappropriate for the community. I realize that if I do not meet my financial obligation and other stipulations of the SLC *Residency Agreement*, my tenancy will be terminated.

I understand that all monies owed (administrative charges, security deposit and first month's room/board/personal care) must be paid in full prior to being allowed to gaining access to the unit that I will be renting.bmcgin

I certify that the information given in this application is true to the best of my knowledge. I understand that any false information could be grounds for cancellation of the application or termination of residency after occupancy.

Applicant_____Date _____

Applicant's Power of Attorney_____Date _____

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the Senior Living Community and its staff to obtain any information or materials deemed necessary to determine my eligibility for housing, including contacting agencies, offices, groups or organizations, which may provide information that could substantiate or verify information given in this application (i.e. local police departments, welfare agencies or senior service agencies) and to obtain my credit report.

Applicant_____Date _____

Applicant's Power of Attorney_____Date _____

To be completed by applicant or legal representative

I,_____, hereby authorize and direct my Physician,

_____, to completely and fully answer all the

questions under "Physician's Statement" below as part of my application for residence at the

Assisted Living Center-Salisbury.

_____ _____

Applicant / Legal Representative Signature Date

Print Applicant's Name:_____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone:_____ Other: _____

Physician's Name: _____

Physician's Address: _____

City: _____ State: _____ Zip Code: _____

Telephone:_____ Fax: _____

Physician's Statement (to be completed by your physician)

Your patient has applied for residency at the ***Assisted Living Center-Salisbury*.** Each resident will receive a full package of services: 3 meals daily, housekeeping weekly, and personal care service, i.e., assistance with bathing, grooming, and dressing, emergency response system and service coordination. Please know that your patient will live independently and must be self-reliant. If any of your responses need additional space, please provide the information on a separate sheet.

Per the Commonwealth of Massachusetts' Assisted Living Regulations (651 CMR 12.04 (7), this completed form needs to be returned or faxed back to the address listed on the last page of this form in order to complete this person's application. Thank you for your assistance

Please indicate primary diagnosis: _____

Significant past medical history: _____

_____

_____

Present cognitive status (including by way of example and not limitation) confusion, long and short-term memory, depression, etc. _____

_____

Is applicant oriented to: Time: _____ Place: _____ Person: _____

Please describe any behavioral concerns, which might help us in our service planning:

_____

_____

Present psychosocial status: _____

_____

_____

Present physical health status: _____

_____

_____

Current medication(s): _____

_____

_____

Any known drug reactions: _____

_____

_____

Is Applicant able to follow your prescribed medical regime(s): Yes: ☐ No: ☐

If no, please explain: _____

_____

TB Test: Yes: ☐ No: ☐ Date: _____ Result: _____

Physician Report Form

Please describe any sensory impairment:

Vision:_____

Hearing: _____

Blood Pressure Reading: _____

Has the Applicant suffered from any illness during the past five years that would impair his/her health

Physically? Yes: ☐ No: ☐ If yes explain: _____

Cognitively? Yes: ☐ No: ☐ If yes explain: _____

Psychosocially? Yes: ☐ No: ☐ If yes explain: _____

Hospitalization(s) during the past five years? Yes: ☐ No: ☐ If yes explain: _____

_____

_____

Is the Applicant on a special diet? Yes: ☐ No: ☐ If yes please explain any dietary restrictions and how we might comply: _____

_____

Please indicate the Applicant's need for assistance with activities of daily living: _____

_____

_____

Will the Applicant need any of the following appliances or durable medical equipment?

Walker: Yes: ☐ No: ☐ Cane: Yes: ☐ No: ☐ Wheelchair: Yes: ☐ No: ☐

Other equipment (please specify): _____

Please identify any other special needs the Applicant may require, and how they might be accommodated:

_____

_____

_____

Physician Report Form

Your answers to the following questions will help our Program Nurse plan for the Applicant once he/she has moved into our community.

Has the Applicant had any of the following diseases or disorders? Please circle yes or no. If yes, please provide any additional information, which will aid in our service planning for the Applicant.

Heart Disease: **Yes No** _____

Infarcts: **Yes No** _____

Angina: **Yes No** _____

Stroke: **Yes No** _____

Emphysema: **Yes No** _____

Paralysis: **Yes No** _____

Diabetes **Yes No** _____

Epilepsy: **Yes No** _____

Cancer: **Yes No** _____

Hip Fracture(s) **Yes No** _____

Urinary Problems **Yes No** _____

Incontinence **Yes No** _____

Hernias: **Yes No** _____

Arthritis: **Yes No** _____

Allergies: **Yes No** _____

Skin Conditions: **Yes No** _____

Hemorrhages: **Yes No** _____

Aphasia: **Yes No** _____

Communicable Disease HX: **Yes No** _____

Emergency Assist: **Yes No** _____

Additional Comments:_____

_____

Primary Physician's Name: _____

Primary Physician's Signature: _____

Date: _____

The date of his/her last physical examination is _____.

Physician Summary Form

Patient

Last name	First name	Date of birth	Gender F M	SSN

Diagnosis

Diagnosis(es)	☐ Mental retardation
Psychiatric diagnosis / **Psychosocial History**	☐ Developmental disability

Treatments
List type and frequency.

Medications taken
List drug, dose, route, and frequency.

Ordered therapies
by a licensed professional (OT, PT, ST, etc.)

Recent vital signs		**Allergies**	**Height**	**Continence**		**Mental Status**
Date:	T:	☐ No known allergies ☐ No known drug allergies		Bowel	Bladder	☐ Alert & oriented
	P:	☐ Allergies, list:	**Weight**	☐ Continent	☐ Continent	☐ Alert & disoriented
	R:			☐ Incontinent	☐ Incontinent	☐ Other:
	BP:			☐ Colostomy	☐ Catheter	

Additional comments/Special needs

Lab work

Date of last PE.

Date of last office visit

Patient's Goals in Assisted Living

Signature _____ MD/NP/PA (circle one)

Print name _____ Date completed _____