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 page 8
Everyone needs to sign

RELEASE OF INFORMATION AUTHORIZATION page 8
Everyone needs to sign

PHYSICIAN REFERRAL FORM pages 9-12
Everyone need to have completed by their primary care physician

GENERAL PHYSICIAN SUMMARY FORM page 13
All applicants need to have this form completed by their primary care physician

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** ______________________

Angina: **Yes No** ______________________

Emphysema: **Yes No** ______________________

Diabetes **Yes No** ______________________

Cancer: **Yes No** ______________________

Urinary Problems **Yes No** ______________________

Hernias: **Yes No** ______________________

Allergies: **Yes No** ______________________

Hemorrhages: **Yes No** ______________________

Infarcts: **Yes No** ______________________

Stroke: **Yes No** ______________________

Paralysis: **Yes No** ______________________

Epilepsy: **Yes No** ______________________

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

Incontinence **Yes No** ______________________

Arthritis: **Yes No** ______________________

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

Lab work	Date of last P.E.
	Date of last office visit

Additional comments/Special needs

Patient's Goals in Assisted Living

Signature ______________________ MD/NP/PA (circle one)

Print name ______________________ Date completed ______________