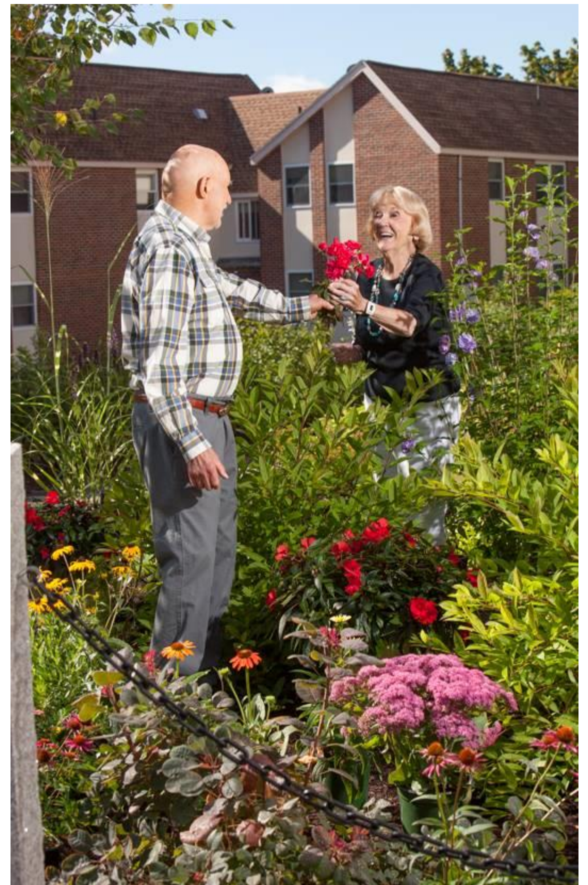
Application for Residence



Assisted Living Center – Salisbury

19 Beach Road
Salisbury, Massachusetts
978 463-9809
978 463-3009 Fax
www.assistedlivingcenter.org

Date Application Received ______________

Application for Residence/Admission to the Assisted Living Center-Salisbury

A. Personal Information

Applicant's Name: ____________________________________ Maiden Name: ____________________

Address: ____

Home Phone: ______________________ Birth date: ________/_______/________

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

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 Assisted Living Center - Salisbury concept is to provide affordable housing to frail and disabled elderly who are medically stable but unable to live independently. The availability of comprehensive, on-site services should allow them continued participation in community life and to avoid premature, long term care/nursing home placement. 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.)

Medicaid: State_____ #_______________

MassHealth # _________________

Commonwealth Care Alliance/Senior Care Options (SCO) # ___________________________

Medicare #____________________

Supplemental Health Insurance___________________________

Policy # __________

Monthly amount $__________

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

____

____

Forms

GENERAL CERTIFICATION **page 8**
Everyone needs to sign

RELEASE OF INFORMATION AUTHORIZATION **page 8**
Everyone needs to sign

CORI REQUEST FORM **page 9**
Everyone needs to sign

PHYSICIAN REFERRAL FORM **pages 10 - 13**
Everyone need to have completed by their primary care physician

GENERAL PHYSICIAN SUMMARY FORM **page 14**
Everyone *other than MassHealth/GAFC applicants* need to have this form completed by their primary care physician

MASS HEALTH PHYSICIAN SUMMARY FORM **page 15**
***Only MassHealth/GAFC applicants* need to have their primary care physician complete this form**

GENERAL CERTIFICATION

I understand that all payments owed by the applicant tenant must be made prior to occupancy. I certify that The Assisted Living Center will be my primary residence.

I understand that tenant selection is based on a number of factors, primarily on the assessment of ALC'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 ALC *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.

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 Assisted Living Center, Inc. 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 _______________

Assisted Living Center ~ Salisbury

"A Community Built on a Lifetime of Experiences"

19 Beach Road • Salisbury, Massachusetts 01952

phone: 978 • 463 • 9809 fax: 978 • 463 • 3009 www.assistedlivingcenter.org

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES

Assisted Living Center-Salisbury is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for the rental or lease of housing.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to **Assisted Living Center-Salisbury** to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing **Assisted Living Center-Salisbury** with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY: The **Assisted Living Center-Salisbury** may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that **Assisted Living Center-Salisbury** must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

______________________________ ______________________________

SIGNATURE DATE

SUBJECT INFORMATION:

____
Last Name First Name Middle Name Suffix

____
Maiden Name (or other name(s) by which you have been known)

________________ ______________________________
Date of Birth Place of Birth

Last Six Digits of Your Social Security Number (Requested, not required): _______-_________

Sex: ____ Height: ___ft. __in. Eye Color: _________ Race: __________

Driver's License or ID Number: ____________________ State of Issue: ________

____ ____________________________________
Mother's Full Name Mother's Maiden Name

____
Father's Full Name

Current and Former Addresses:

____
Street Number & Name City/Town State Zip

____
Street Number & Name City/Town State Zip

____
The above information was verified by reviewing the following form(s) of government issued identification:

____

____

VERIFIED BY: ____
Printed Name of Verifying Assisted Living Center – Salisbury Employee

____
Signature of Verifying Employee / Date

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Physician Referral Form

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.

Physician Referral Form

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: _________

Assisted Living Center ~ Salisbury

Physician Referral 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 Referral 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 __________________.

Please return this completed form to:

Assisted Living Center-Salisbury
19 Beach Road
Salisbury, MA 01952

Contact: Donna Mills, RN Program Nurse
Telephone: (978) 463-9809
Fax: (978) 463-3009

Physician Summary Form

Patient

Last name	First name	Date of birth	Gender F M	SSN

Diagnosis

Diagnosis(es)	☐ Mental retardation
Psychiatric diagnosis	☐ Developmental disability

Treatments

List type and frequency.

Ordered therapies

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

Medications taken

List drug, dose, route, and frequency.

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 P.E.

Date of last office visit

I recommend this patient for the following service(s)

☐ Adult day health (ADH)	☐ Group adult foster care (GAFC)	☐ Adult foster care (AFC)	☐ Program for All-inclusive Care for the Elderly (PACE)	☐ Nursing facility (NF)

Signature ______________________ MD/NP/PA (circle one)

Print name ______________________ Date completed ______________

PSF-1 (07/02)

Physician Summary Form

Patient

Last name	First name	Date of birth	Gender F M	SSN

Diagnosis

Diagnosis(es)	☐ Mental retardation
Psychiatric diagnosis	☐ Developmental disability

Treatments

List type and frequency.

Ordered therapies

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

Medications taken

List drug, dose, route, and frequency.

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

Additional comments/Special needs

Lab work

Date of last P.E.

Date of last office visit

I recommend this patient for the following service(s)

☐ Adult day health (ADH)	☐ Group adult foster care (GAFC)	☐ Adult foster care (AFC)	☐ Program for All-inclusive Care for the Elderly (PACE)	☐ Nursing facility (NF)

Signature ______________________ MD/NP/PA (circle one)

Print name ______________________ Date completed ____________

PSF-1 (07/02)