Assisted Living Center - Salisbury

The Affordable Alternative

Full Application for Residency
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: _____/_____ /_____

Who shall we contact about this application?

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**  $ __________
### Financial Information: Assets

#### Checking Accounts

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#### Savings Accounts

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#### Certificates of Deposits, etc.

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#### Trust Accounts

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#### Stocks, Bonds (specify)

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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 # _______________

SCO # ___________________________ 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

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 ______________
CORI REQUEST FORM

Assisted Living Center, Inc. has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an applicant into the assisted living program and for residence at ALCI, I understand that a criminal record will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

_____________________________________________
Applicant Signature

APPLICANT INFORMATION (PLEASE PRINT)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
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Maiden Name or Alias (if applicable)

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<tr>
<th>Date of Birth</th>
<th>Social Security Number</th>
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Street Address

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<tr>
<th>Apartment/Unit #</th>
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Mailing Address (if different)

<table>
<thead>
<tr>
<th>City/Town</th>
<th>State</th>
<th>Zip</th>
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Requested by: _______________________
Signature of CORI Authorized Employee (ALC Management Signature)
**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.

<table>
<thead>
<tr>
<th>Applicant / Legal Representative Signature</th>
<th>Date</th>
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</thead>
</table>

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: ________
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:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
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: Deb Fichera, RN  Program Nurse
Telephone: (978) 463-9809
Fax: (978) 463-3009
## Physician Summary Form

### Patient

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<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Date of birth</th>
<th>Gender</th>
<th>SSN</th>
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### Diagnosis

- **Diagnoses:**

- **Psychiatric diagnosis / Psychosocial History:**

- Mental retardation
- Developmental disability

### Treatments

**List type and frequency:**

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### Medications taken

**List drug, dose, route, and frequency:**

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### Ordered therapies

**by a licensed professional (OT, PT, ST, etc):**

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### Recent vital signs

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<th>Date:</th>
<th>Allergies</th>
<th>Height</th>
<th>Continence</th>
<th>Mental Status</th>
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<tr>
<td>T:</td>
<td>☐ No known allergies</td>
<td>☐ No known drug allergies</td>
<td>☐ Bowel</td>
<td>☐ Alert &amp; oriented</td>
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<tr>
<td>P:</td>
<td>☐ Allergies, list:</td>
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<td>☐ Continent</td>
<td>☐ Alert &amp; disoriented</td>
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<td>R:</td>
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<td></td>
<td>☐ Incontinent</td>
<td>☐ Other:</td>
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<td>BP:</td>
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<td>☐ Incontinent</td>
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### Allergies

- ☐ No known allergies
- ☐ No known drug allergies
- ☐ Allergies, list:

### Height

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### Continence

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### Mental Status

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### Weight

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### Lab work

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### Date of last PE.

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### Date of last office visit

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### Additional comments/Special needs

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### Patient’s Goals in Assisted Living

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### Signature

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### Print name

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