



Assisted Living Center - Salisbury

The Affordable Alternative

Full Application for Residency



Date Application Mailed _____

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: ____/____/____

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 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 # _____

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 _____



ALEIN
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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)

Last Name First Name Middle Name

Maiden Name or Alias (if applicable)

Date of Birth Social Security Number

Street Address Apartment/Unit #

Mailing Address (if different)

City/Town State Zip

Requested by: _____
Signature of CORI Authorized Employee (ALC Management Signature)



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

Physician Referral Form page 1 of 4

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 page 2 of 4

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 Referral Form page 3 of 4

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 page 4 of 4

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

Last name	First name	Date of birth	Gender F M	SSN
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Diagnosis

Diagnosis(es)	<input type="checkbox"/> Mental retardation
Psychiatric diagnosis / Psychosocial History	<input type="checkbox"/> 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	Continance	Mental Status
Date: T: _____ P: _____ R: _____ BP: _____	<input type="checkbox"/> No known allergies <input type="checkbox"/> No known drug allergies <input type="checkbox"/> Allergies, list: _____	_____	Bowel: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy <input type="checkbox"/> Catheter	<input type="checkbox"/> Alert & oriented <input type="checkbox"/> Alert & disoriented <input type="checkbox"/> Other: _____
		Weight		

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 _____



Physician Summary Form

Patient

Last name	First name	Date of birth	Gender F M	SSN
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Diagnosis

Diagnosis(es)	<input type="checkbox"/> Mental retardation
Psychiatric diagnosis	<input type="checkbox"/> 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 Date: T: _____ P: _____ R: _____ BP: _____	Allergies <input type="checkbox"/> No known allergies <input type="checkbox"/> No known drug allergies <input type="checkbox"/> Allergies, list: _____ _____	Height _____	Continenence		Mental Status <input type="checkbox"/> Alert & oriented <input type="checkbox"/> Alert & disoriented <input type="checkbox"/> Other: _____
		Weight _____	Bowel <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy	Bladder <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter	
		Lab work _____ _____ _____		Date of last PE. _____	
				Date of last office visit _____	

Additional comments/Special needs

I recommend this patient for the following service(s)

<input type="checkbox"/> Adult day health (ADH)	<input type="checkbox"/> Group adult foster care (GAFC)	<input type="checkbox"/> Adult foster care (AFC)	<input type="checkbox"/> Program for All-inclusive Care for the Elderly (PACE)	<input type="checkbox"/> Nursing facility (NF)
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Signature _____ MD/NP/PA (circle one)
 Print name _____ Date completed _____

PSF-1 (07/02)