1215 Centre Street
West Roxbury, MA 02132
617-325-7900

ADMISSIONS APPLICATION

Date: ________________

Social Security No.: ________________

A. Introductory Information

1. Applicant's Name: ____

2. Present Address: ____

____

How long at this address? ______________________________

3. Telephone Number: (   )________________________

4. Previous Address: ____

____

5. Date of Birth: ____________________________

6. Birthplace: ____

7. U.S. Citizen? YES ___ NO _____

8. Maiden Name: ____

9. Father's Full Name: ____

10. Mother's Full Name: ____

11. Current Marital Status:

Single ____ Married ____ Widowed ____ Divorced ____ Separated ____

12. Number of Children: ________________

Name	Address	Home Phone	Work Phone

13. Other Relatives or Interested Friends:

Name	Address	Home Phone	Work Phone

B. Background Information

1. Education:

a. High School: ____

b. Other: ____

2. Occupations: ____

____

____

____

When last employed? ____

3. Membership in Organizations: ____
____
____
____

4. Recreational Interests and Hobbies: ____
____
____
____

5. Religious Affiliation: ____

   Contact Person: ____

6. Cemetery: ____

   Deed held by: ____

   Burial Insurance: ____

   Funeral Director: ____

<u>C. Medical Information</u>:

1. Name of your primary physician: ____

   Address: ____

   ____

   Phone: ___________________________________

2. Date of last treatment or examination: ____

3. List hospitalization(s) within the last ten years: _________________________________
____
____
____
____

4. Are you currently taking any medication? Yes ____ No ____

If yes, list name(s) of medications: ____

____

____

5. Do you know of any condition (injury, disease, impairment) affecting your physical or mental health which is not referred to on the accompanying report by your physician? Yes ___ No __
If yes, please describe: ____

____

____

(**PLEASE NOTE:** ***Any known physical or mental condition not disclosed prior to admission may be grounds for termination of residency***.)

6. Please describe any special dietary needs: ____

____

____

7. Please check those activities with which you now need some assistance:

___ Taking medication on a scheduled basis

___ Using a telephone

___ Climbing stairs

___ Walking

___ Getting out of bed

___ Bathing or showering

___ Preparing meals on a daily basis

___ Dressing

___ Getting in and out of a car

___ Bladder or bowel control

___ Personal and/or grocery shopping

___ Laundry

8. Have you made provision for:

   Do Not Resuscitate(DNR)/Comfort Care Directives Yes ___ No ___

   Health Care Proxy Yes ___ No ___

   Power of Attorney Yes ___ No ___

9. Have you ever been a resident of another retirement or nursing home?

   Facility Name Dates

   ____

   ____

D. Hospital and Medical Insurance Coverage

1. Do you have any coverage for hospital and medical expenses? Yes ___ No ___

   Medicare No.: ____

   MedEx No.: ____

   Other Medical Coverage: ____

   Prescription Plan: ____

E. Declaration of Finances

You are asked to complete the following financial section of the application. Should you at any time have questions or concerns, please contact the Executive Director. This statement must be updated at the time of admission and periodically thereafter, when requested to do so.

The Home respects the privacy of every applicant and does not wish to intrude into any applicant's personal financial circumstances other than to determine that the financial requirements for the applicant's personal and medical needs can be adequately met.

Disclosure is not required of the applicant's total estate, but rather only of sufficient assets to cover monthly charges, and personal needs and obligations. A SIGNED STATEMENT OF FINANCIAL RESOURCES FROM A TRUST OFFICER OR OTHER FINANCIAL ADVISOR SETTING FORTH SUBSTANTIALLY IDENTICAL INFORMATION TO THAT REQUESTED BELOW MAY BE SUBMITTED IN LIEU OF COMPLETION OF SECTION E OF THIS FORM. All financial information will remain confidential.

The following advisors and their firms (give names and addresses) may be consulted regarding my application for admission:

Bank: ____________________
Address: ____________________
Telephone: ____________________

Investment Advisor: ____________________
Address: ____________________
Telephone: ____________________

Attorney: ____________________
Address: ____________________
Telephone: ____________________

Trustee: ____________________
Address: ____________________
Telephone: ____________________

Individual responsible for paying bill (with Applicant funds), if other than Applicant.

Name: ____________________ Social Security No. ____________________

Relation to Applicant: ____________________

Home Address: ____________________

____

Home Phone: ____________________ Work Phone: ____________________

Fax: ____________________ Email: ____________________

1. Assets

(a) Real Property:

Real estate location	Net Value (current value minus mortgage balance)	Held jointly?
____________	____________	____________
____________	____________	____________
____________	____________	____________

a: Total Real Estate Value: ____________________

(b) Bank Accounts:

Name of Financial Institution	Account Type	Current Balance	Estimated Annual Income
______________________________	______________	______________	_____________
______________________________	______________	______________	_____________
______________________________	______________	______________	_____________
______________________________	______________	______________	______________
______________________________	______________	______________	______________

(c) Investment Accounts:

Location	Type(mutual fund,stock)	Current Balance	Estimated Annual Income
_____________________________	_______________	_____________	_____________
_____________________________	_______________	_____________	_____________
_____________________________	_______________	_____________	_____________
_____________________________	_______________	_____________	_____________

(d) Life Insurance:

Does the applicant have life insurance policies with cash value? Yes ____ No ____

a. Approximate cash value $ ________________________

b. Annuities $ ________________________

c. Company Name ____

(e) Long Term Care Insurance:

Does the applicant have long term care insurance? Yes ____ No ____

(if No please proceed to section 2)

a. Approximate cash value $ _______________________

b. Length of benefit ________________________

c. Company Name ____

2. Resources

(a) Monthly Income		**(b) Assets**	
		Checking Accounts	**$ ____________**
Social Security	$____________	Savings Accounts	$ ____________
Pensions	$ ____________	Bonds	$ ____________
Annuities	$ ____________	Stocks/Investments	$ ____________
Interest & Dividends	$____________	Annuities	$ ____________
Other	$ ____________	Real Estate	$ ____________
(indicate source)____________________		(Indicate value of home less any outstanding mortgage balances) $____________	
	$ ____________		
Other	$ ____________	Long Term Care Ins. (net cash values)____________________	
(indicate source)____________________		Life Insurance- indicate full amount,i.e.,amount available to others upon your death -$ ____________	
Total Monthly Income*	$ ____________	**Total Assets**	$ ____________

(*) **We request income tax returns for the three most recent years**.

(c) Are any of the above assets held jointly? No ___ Yes ___ If Yes, please explain: ________

____

____

(d) Are all of the above assets intended for the care of the applicant? No ___ Yes ___

If No, please explain: ____

____

(e) Are there any obligations against, or restrictions on, any of these assets? No _____ Yes ___

If Yes, please explain: ____

____

(f) Are any of these assets held in trust? No ___ Yes ___ If Yes, please explain: __________

____

____

a. Trust Officer's Name and Address: ____

____

3. Annual Expenses

Health/Medical Insurance $ _________________

Prescriptions $ _________________

Federal & State Taxes $ _________________

Estimated Personal Expenses $ _________________

(i.e. clothing,gifts,subscriptions,memberships,personal grooming, credit cards, etc.)

Automobile Expenses $ _________________

(i.e. maintenance, insurance, registration, etc.)

Other $ _________________

Total Annual Expenses $ _________________

Is it your belief that your income and assets (remaining after payment of Entry Fee) will be adequate to meet your Monthly Fee to the Home and your other living expenses during your residence at the Home? Yes ____ No ____ If No, please explain: ____________________

____

____

____

____

These statements are true to the best of my/our knowledge and belief. I/We agree that I/we will not make substantial gifts or transfer assets or surplus income such that my/our remaining assets will become insufficient to meet my/our financial obligation to the Home.

Signature: ____________________________________   Date: ___________________________

(Applicant)

Signature: _____________________________________   Date: ___________________________

(Individual responsible for paying Applicant's bills, if other than Applicant. See Page 6)