APPLICATION FOR RESIDENCY

CHOATE-Woburn

☐ Independent Living
☐ Assisted Living

MARLBOROUGH

☐ Independent Living
☐ Full Service Retirement
☐ Assisted Living

We are pleased that you wish to join our New Horizons community! To arrange for accommodations, it is necessary that you first complete this Application for Residency and submit it with a $50 Application Fee payable to *New Horizons*. This application, in combination with the physician's statement and an interview with an admissions committee member, will assist us in determining approval. We look forward to hearing from you soon and to your joining this wonderful retirement community.

GENERAL (one application per person)

Applicant's Name: ______________________________ Email: ______________

Birth Date: ____________ Birth Place: ______________ Current/former occupation: ______________

Permanent Address: ____
(Street) (City, State and ZIP)

Present Address (if different): ____

How long at present address? __________ Telephone: (h)______________ (cell)______________

Marital Status: ______________ Veteran: Yes ☐ No ☐ Spouse of Veteran: Yes ☐ No ☐

FINANCIAL

Assets (couples may complete *jointly* on one application)

Bank Account(s) $______________
Certificates of Deposit $______________
Stocks & Bonds, etc. $______________
Real Estate $______________
401(k) / IRA $______________
Other Major Assets* $______________
TOTAL ASSETS $______________

Liabilities (couples may complete *jointly* on one application)

Home Mortgage $______________
Other Loans* $______________
TOTAL LIABILITIES $______________

*Please describe on a separate page

TOTAL NET WORTH (Assets minus Liabilities) $______________

Monthly Income (couples shall complete *separately*)

Employment Income $________ per month
Social Security Income $________ per month
Employee Pension Income $________ per month
401(k)/IRA Distribution $________ per month
Interest/Dividend Income $________ per month
Rental Income $________ per month
Family Assistance $________ per month
Other ______________ $________ per month
TOTAL INCOME $________ per month

AGENTS and GUARANTOR (required of all applicants)

Name and address of *Guarantor*:

Name: ______________________________ Email: ______________

Address: ______________________________ Phone: ______________
(Street) (City, State and ZIP)

Name and address of *Power of Attorney*:

Name: ______________________________ Email: ______________

Address: ______________________________ Phone: ______________
(Street) (City, State and ZIP)

Name and address of *Health Care Agent*:

Name: ______________________________ Email: ______________________________

Address: ______________________________ Phone: ______________________________
(Street) (City, State and ZIP)

Name and address of *Billing Party (if other than self)*:

Name: ______________________________ Email: ______________________________

Address: ______________________________ Phone: ______________________________
(Street) (City, State and ZIP)

HEALTH -- SELF-ASSESSMENT

1. Do you live alone? Yes: ______ No: _______
2. Do you smoke? Yes: ______ No: _______
3. Is it helpful when family or friends check in with you frequently throughout the day? Yes: ______ No: _______
4. Do you require others to prepare meals for you? Yes: ______ No: _______
5. Do you require others to assist you with your medications by:
   a. reminding you to take medication? Yes: ______ No: _______
   b. filling weekly medication cassettes for you? Yes: ______ No: _______
   c. arranging for prescription refills? Yes: ______ No: _______
6. Do you currently take medication that helps with your memory? Yes: ______ No: _______
7. Do you feel unsteady or unsafe in the bathroom at times? Yes: ______ No: _______
8. Is it helpful for you to have someone assist you with toileting? Yes: ______ No: _______
9. Is it helpful to use a walker and/or a wheelchair to get around? Yes: ______ No: _______
10. Have you had a fall in the past six months? Yes: ______ No: _______

    If yes, please describe: ______________________________

LEVEL OF DAILY ACTIVITY

	Good	Fair	Poor		Good	Fair	Poor		Good	Fair	Poor
Housekeeping	_____	_____	_____	Exercise	_____	_____	_____	Shopping	_____	_____	_____
Taking medication	_____	_____	_____	Walk unassisted	_____	_____	_____	Laundry	_____	_____	_____
Fire awareness	_____	_____	_____	Transportation	_____	_____	_____	Budgeting	_____	_____	_____

PRIMARY CARE PHYSICIAN

Name: ______________________________ Email: ______________________________

Address: ______________________________ Phone: ______________________________

ADDITIONAL INFORMATION

Past/present clubs, civic involvement, etc: ______________________________

Personal strengths and interests: ______________________________

____

I understand and agree that the foregoing application is not a contract or reservation for residence at New Horizons and that nothing contained herein is binding on any party until a Residence Agreement has been signed by the parties hereto. I certify that the information which I have provided in this Application for Residence is true and correct to the best of my knowledge and belief as of the date hereof. I authorize you to make any necessary inquiries for the purpose of verifying this or any other information provided. I further agree to promptly notify the Executive Director in the event of any material financial change hereto. These statements are made under the penalties of perjury.

Date: ______________________ Signed: ______________________________
Applicant (or Authorized Representative)

(New Horizons Use Only)
Interviewer: Date: Physician's Stmt Rec'd: Fee Paid: Approval Date:

PHYSICIAN'S STATEMENT

Woburn ☐ Marlborough ☐

I, ______________________________, hereby authorize and request my physician, ______________________________, to release and furnish all information regarding my medical history and current medical status to New Horizons, in conjunction with my application for residency at that facility. I further authorize any other health care providers and facilities to release future health care records and related information to New Horizons' Executive Director.

________________ Date ______________________________ Applicant (or Authorized Representative)

Please print clearly to expedite this application process.

Applicant's name:______________________________Date of birth:________________

Note to physician: Your patient has applied for entrance to our New Horizons senior community, which offers a continuum of programs, including:

(1)* **Apartment-style independent living** – includes one meal daily, with an option for another meal, at additional cost; living accommodation is a typical apartment with full kitchen in multi-story buildings.
(2) **Independent living with hospitality services** – includes three meals daily, plus light housekeeping and linen laundering; suite living accommodation includes kitchenette.
(3) **Assisted living** – includes same services as (2), plus access to home health aides for assistance with activities of daily living at additional cost, e.g. bathing, dressing, escorts to meals and activities, etc.
(4) **Alzheimer care wing** – a secure facility, independently operated, offering the same services as (2), plus special care services tailored to individuals living with Alzheimer's or related dementias.
(5)* **Mental health enhanced care unit** – a secure facility, independently operated, offering the same services as (2), plus special care services tailored to individuals suffering from conditions such as acute anxiety disorder or depression.

* Programs (1) and (5) are available at the Marlborough facility only.

Neither facility (Woburn or Marlborough) provides long-term nursing care or skilled nursing services. Please keep these factors in mind as you evaluate your patient's present physical and mental health. If any answer herein requires additional space, please feel free to supplement this form.

Once completed, this form must be received by New Horizons before any action can be taken on the application. Thank you in advance for your vital, timely assistance. Please **mail** or **fax** this form to whichever facility is indicated above:

New Horizons at Choate, LLC ▪ **21 Warren Avenue** ▪ **Woburn, MA 01801** ▪ **fax: 781-938-8355**

New Horizons at Marlborough, LLC ▪ **400 Hemenway Street** ▪ **Marlborough, MA 01752** ▪ **fax: 508-460-7682**

Present health status:______________________________

____

Allergies:______________________________

Special diet:______________________________

Current medications:______________________________

____

Medical history:______________________________

____

____

Recent hospitalizations (last five years) and diagnoses:______________________________

____

____

Is Applicant able to independently and accurately follow your prescribed medical regime?______________

Comments:______________________________

____

Is Applicant able to independently perform the activities of daily living?______________

Comments/limitations:______________________________

Does Applicant use a walker? ___________ Cane? _____________ Wheelchair? __________________

If wheelchair is used, can Applicant transfer on his/her own? ________________

Does Applicant have difficulty with stairs?________________

Is Applicant oriented as to: Time?________________ Place?_______________ Person?__________________

Does Applicant have appropriate behavior patterns?______________________________

Please answer yes or no if Applicant has or has had a history of any of the following diseases or disorders.

Angina:______________	Asthma:________________	Sensory deficits:____________	Epilepsy/seizures:__________
Arrhythmia:___________	COPD:_________________	Visual:_________________	Parkinson's:_______________
CHF:________________	Arthritis:_______________	Auditory:________________	Dementia:________________
Hypertension:_________	Osteoporosis:____________	Speech:_________________	Anxiety:_________________
MI:__________________	Alcohol abuse:___________	Cancer:__________________	Depression:_______________
CVA:________________	Drug abuse:_____________	Eating disorder:____________	Decubiti/skin cond.:________
Emphysema:___________	Incontinence:____________	Diabetes:_________________	Communicable disease:_____

If you answered yes to any of the above, please supply supplemental information including dates and prognosis:

____

____

____

Will you continue to follow Applicant after his/her move to New Horizons? ______________________________

General comments:______________________________

____

Immunization (dates): Tetanus:__________ Influenza:__________ Pneumococcal:___________

Per CDC guidelines, all applicants must have a tuberculosis screening within 90 days prior to move-in:

Mantoux Test Results: Step 1 Negative ________mm Positive ________mm Date __________________

Step 2 Negative ________mm Positive ________mm Date __________________

X-ray results: Date __________ ☐ Normal ☐ Abnormal/TB ☐ No TB Infection ☐ Non-active TB Infection ☐ TB Suspect

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I recommend this applicant for residence at New Horizons:

☐ (1) **Apartment-style independent living** (*Marlborough only*)
☐ (2) **Independent living with hospitality services**
☐ (3) **Assisted living**
☐ (4) **Alzheimer care wing**
☐ (5) **Mental health enhanced care unit** (*Marlborough only*)

Physician's name:______________________ Signature:____________________ Date:______________

Address:______________________________ Phone (____)______________