New Horizons
This is home!

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: