



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) | Date: | Physician's Stmt Rec'd: | Fee Paid: | Approval Date: |
| Interviewer: | | | | |



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

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 (____) _____