



APPLICATION FOR RESIDENCY

Choate

Marlborough

We are pleased that you wish to join this New Horizons community. To arrange for accommodations, it is necessary that you first complete this Application for Residence. Once completed, this form should be returned immediately with the \$300 Application Fee, to the appropriate address shown below. Shortly thereafter, you should submit a physician's statement and arrange for a final interview. We look forward to hearing from you soon and to your joining this wonderful retirement community.

General

Applicant's Name: _____ Telephone: (_____) _____

Permanent Address: _____ Zip: _____

Present Address (if different): _____

How long at present address? _____ Birth Date: _____ Birth Place: _____

Marital Status: _____ Veteran? Yes: ___ No: ___ Current or former occupation: _____

Person to be contacted in case of an emergency:

Name: _____ Relation: _____ Telephone: (_____) _____

Address: _____ Zip: _____

Living Accommodations

Please describe your present living accommodations: _____

Type of accommodations you are applying for (check one) Independent Living Assisted Living

Please describe any special needs or concerns of which New Horizons' staff should be aware: _____

Do you currently rely on a relative, friend or home health aide to live with and/or assist you? Yes: _____ No: _____

Who? _____ Why? _____

Do you anticipate a need for either part time or 24-hour personal care/assistance? Yes: _____ No: _____

Medical

Physician's name: _____ Telephone: (_____) _____

Address: _____ Zip: _____

How would you describe your current state of health? _____

How often do you presently see a doctor? _____

Are you on medication(s) at the present time? Yes: _____ No: _____

If so, for what condition(s)? _____

Do you require assistance to administer medication? Yes: _____ No: _____ Do you have medical insurance? Yes: _____ No: _____

Do you have difficulty with stairs? Yes: _____ No: _____ Do you smoke? Yes: _____ No: _____

Do you prepare your own meals? Yes: _____ No: _____ Are you on a special diet? Yes: _____ No: _____

Level of Daily Activity

	Good	Fair	Poor		Good	Fair	Poor		Good	Fair	Poor
Housekeeping	_____	_____	_____	Transportation	_____	_____	_____	Shopping	_____	_____	_____
Taking medication	_____	_____	_____	Walking	_____	_____	_____	Laundry	_____	_____	_____
Fire awareness	_____	_____	_____		_____	_____	_____	Budgeting	_____	_____	_____
Past/present clubs, civic involvement, etc: _____											
Personal strengths and interests: _____											

Financial (married couple complete jointly)

Assets	Amount	Liabilities	Amount Owed
Bank Account(s)	\$ _____	Home Mortgage	\$ _____
Certificates of Deposit	\$ _____	Other Loans	\$ _____
Stocks & Bonds	\$ _____	TOTAL LIABILITIES:	\$ _____
Real Estate	\$ _____		
401(k) / IRA	\$ _____		
Other Major Assets	\$ _____		
TOTAL ASSETS:	\$ _____	TOTAL NET WORTH:	\$ _____
		(Assets minus Liabilities)	

Please describe the nature of your financial resources:

Employment income:	\$ _____ per month	Social Security income:	\$ _____ per month
Pension income:	\$ _____ per month	Interest income:	\$ _____ per month
Family assistance:	\$ _____ per month	Rental income:	\$ _____ per month
Other: _____	\$ _____ per month	TOTAL:	\$ _____ per month

Will your resources cover costs at New Horizons for the foreseeable future? Yes No

Who will be responsible for the actual payment of your bills? Self Other

Name and address of other responsible party/guarantor (required of all residents):

Name: _____ Soc. Sec. #: _____

Address: _____ Telephone: _____

email(s) _____

Additional Information: _____

Power of Attorney _____
Address: _____ Telephone: (_____) _____

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 either 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 Statement 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' designated Continuing Care Coordinator.

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 New Horizons or The Meadows, respectively. To be eligible for the independent living section at New Horizons or The Meadows, each resident must be able to function independently in activities of daily living. The services provided at New Horizons include three meals daily, plus light housekeeping and linen laundering. The Meadows residents have access to one meal as a standard part of their monthly fee and an option for another meal, at additional cost.

In addition to independent living suites, New Horizons offers a special assisted living option with 24-hour certified home health aide staffing and also a separate 24-hour Alzheimer's care center. It does not provide 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 _____

<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal/TB	<input type="checkbox"/> No TB Infection
<input type="checkbox"/> Non-active TB Infection		<input type="checkbox"/> TB Suspect

I recommend this applicant for residence at New Horizons:

<input type="checkbox"/> Independent Living at New Horizons / <i>The Meadows</i>	<input type="checkbox"/> Assisted Living at New Horizons	<input type="checkbox"/> Assisted Living at Hearthstone Alzheimer's Care
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Physician's name: _____ Signature: _____ Date: _____

Address: _____ Phone (____) _____

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

REV.01/09

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