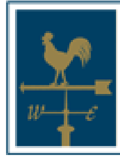

CHRISTOPHER HEIGHTS OF ATTLEBORO

AN ASSISTED LIVING COMMUNITY

(A Low Income Housing Tax Credit Property)

PRELIMINARY APPLICATION FOR RESIDENCY

Please print. Fill in all information. Applications with missing information will not be considered. Please tell management agent if you need assistance.

Date _________________________

I. How did you learn about us?

____

II. General information concerning prospective resident(s):

Applicant's Name ____

Age _____ Date of Birth ____________ Gender ____ Social Security No. ___________

Home Address ________________________________ Telephone Number ____________

Own Home _______ Rent ____________ Occupation ____________________________

Marital Status _________ Spouse's Name ______________________________________

Age _____ Date of Birth ______________ Social Security No. ___________________

Are you or your spouse (living or deceased) a Veteran who was on active duty during a time of war? Yes _______ No _______

Is applicant responsible for managing own finances? Yes ______ No ______

If no, please list name of responsible party:

Name of Responsible Party ____

Address ____

Telephone Number : Business ____________________ Home ____________________

Does applicant have a Power of Attorney (POA)? Yes __________ No ___________

Name ____

Address ____

Telephone Number: Business __________________ Home _____________________

Does applicant have guardian/conservator? Yes ________ No ________

Name ____

Address ____

Telephone Number: Business __________________ Home _____________________

In case of emergency, whom should we notify?

Name _____________________________________ Relationship ________________

Address ____

Telephone Number: Business __________________ Home _____________________

III. Medical information concerning prospective resident:

Primary Physician:

Name __________________________________ Telephone Number ______________

Address ____

Current medical condition(s) ____

____

Past medical condition(s) ____

____

Applicant's physical mobility:

Walks unassisted __________ Uses a cane __________ Uses a walker ____________

Uses a wheelchair _________

Applicant's assistance with daily living requirements:

Grooming Yes _______ No _______

Dressing Yes _______ No _______

Bathing Yes _______ No _______

Mouth/Skin Care Yes _______ No _______

Special Diet Yes _______ No _______

Medication Management Yes _______ No _______

Ambulation Yes _______ No _______

Other special needs ____

Is applicant continent of bowel? Yes _______ No _______

Is applicant continent of bladder? Yes _______ No _______

Does applicant have good eyesight? Yes _______ No _______

Does applicant require oxygen? Yes_____ No _______

Does applicant have colosteomy/ileostomy? ___________ Prosthesis? ____________

Applicant's mental status:

Is applicant alert? Yes _____ No _____ Oriented to time/place? Yes _____ No _____

Is applicant forgetful? ___________ Anxious ____________ Confused ___________

Has applicant been diagnosed with: Dementia _______ Alzheimer's Disease ________

Has applicant been diagnosed as mentally ill or mentally retarded? Yes ____ No____

Please describe temperament of applicant. ______________________________________

Does applicant have need for a handicapped accessible apartment? Yes ____ No _____

Health Insurance: Medicare Number ____________ Medicaid Number_____________

HMO _____________________ **OR** BCBS Medex Number _____________________

Vehicle and Pet Information (if applicable):

Parking will be provided for one (1) vehicle.

Type of Vehicle: _______________________ License Plate # _____________________

Year/Make: __________________________Color:____________________________

Do you own any pets? Yes ___ No __ If so, will they come with you? Yes ___ No___

If yes, describe: ____

I understand and agree that this application is neither a contract nor a reservation for residency. Nothing contained in this document is legally binding on either myself or Christopher Heights of Webster, until a Residency Agreement has been signed and approved by all parties. In addition, acceptance for admission does not constitute acceptance into any third party payment program, which may have a separate criteria for admission.

Applicant's Signature ____

Date ____________________________________

IV. Financial Information

Cash Assets (Please use a separate paper for additional banks if necessary)

Bank ____

Address ____

Checking Account No. ________________________ Balance _____________________

Savings Account No. _________________________ Balance ______________________

Savings Account No. _________________________ Balance ______________________

Certificate of Deposit No. _____________________ Balance ______________________

Certificate of Deposit No. _____________________ Balance ______________________

Annuity: Yes ____No ____ Amount $________ With Whom______________________

Does applicant have stocks and bonds? Yes _______ No _______

Does applicant have Series E/Savings Bonds? Yes____ No ___Trusts? Yes____ No____

Approximate value of securities ____

Other ____

Does applicant have life insurance? Yes ______ No _______ Company _____________

If Yes: Type __________________________ Value _____________________________

Does applicant own a home? Yes _____ No _____ Approximate Value ______________

Is property jointly owned? Yes _____ No _____ With whom? _____________________

Amount of annual insurance premium: _________ Amount of recent tax bill: ________

Does applicant have a mortgage or any outstanding liens on property? Yes ___ No __
Amount _________________ With whom _____________________________________

Does applicant own additional property? Yes ___ No __

Approximate value $____

Income

Social Security Check $_____________/month Pension $___________/month

Veterans $_______________/month

Disability $_____________/month Interest & Dividend Income ____________/month

Annuity Income $____________/month Life Insurance Income $____________/month

Rental Income $_____________/month Other ______________________________

Total Monthly Income $________________________Alimony $ ______________/month

Do you anticipate any change in income in the next 12 months? Yes ______ No _______

Do you have Long Term Care Insurance? Yes _______ No _______

I certify that the information I have given in this Financial Information form is true and correct. Christopher Heights of Webster is an Assisted Living tax credit project, and as such, is required to verify all income and assets of applicants prior to admission. I understand that any false statements or misrepresentations or omissions may result in the cancellation of my application or nullification of my residency agreement. I authorize Christopher Heights of Webster to conduct a review of my financial status and obtain any information necessary to verify my ability to pay for my residency. I further agree to give any written comments required to confirm such information and to cooperate with Christopher Heights of Webster in providing information. I understand it will be necessary to update this information on an annual basis.

Applicant's Signature ________________________________ Date __________________

(If this form is being completed by someone other than the applicant for residency, please print the name of the person completing the information, their relationship to the applicant, and sign on the line below. Please attach a copy of the Power of Attorney or other documentation authorizing a person to act on the applicant's behalf.)

Name ____ Relationship ______________

Signature _______________________________________ Date ______________________

The Grantham Group (the provider of all services for Christopher Heights of Worcester) will, up to the limits of the federal and state disability fair housing law, make reasonable accommodations in policies or reasonable modification of common or unit premises for applicants with disabilities who require such changes to have equal access to any aspect of the application process or to the development and its programs and services. For example, Grantham Group will provide help in completing this application, provide this application in large print or other format, and arrange for sign language interpreters or other communication aids for interviews during the application process.

The Grantham Group, as agent, does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation, age, familial status or physical or mental disability, in the access or admission to its programs or employment, or in its programs, activities, functions or services.

Race (*optional*)

Information will be used for fair housing programs only, as required by state and federal laws.

[ ] American Indian/Alaskan Native [ ] Asian or Pacific Islander

[ ] Black (not of Hispanic origin) [ ] Hispanic [ ] White (not of Hispanic origin)

Size of Apartment needed:

[ ] Studio [ ] Studio Alcove [ ] One Bedroom

Unit Type requested (check as many as apply):

[ ] Low-Income Unit

[ ] Wheelchair Adapted Unit

[ ] Hearing or Visually Adapted Unit

Does any member of the household have any accessibility or reasonable accommodation requests or changes in a unit or development or alternate ways we need to communicate with you? If yes, please explain.

____

Date Apartment Needed: ____________________________

Family Composition – Including yourself, list all those who will occupy the apartment:

Full Name of Each Person Household	Relation to Head of Household	Date of Birth	Gender	Social Security No.
1.____________________	_________________	______	______	_____________
2.____________________	_________________	______	______	_____________
3.____________________	_________________	______	______	_____________

Please respond to these questions if you wish to be considered for a preference.

Are you homeless due to displacement by natural forces?

[ ] Yes [ ] No

Are you homeless due to displacement by public action (urban renewal)?

[ ] Yes [ ] No

Are you homeless due to displacement by public action (sanitary code violations)?

[ ] Yes [ ] No

Are you involuntarily displaced as a result of domestic violence/elder abuse?

[ ] Yes [ ] No

If you answered yes to any of the above questions, please explain.

____

____

____

V. Verifications

The agent will require applicants to sign releases to verify the information below:

- All income, asset, housing history, reference and need for requested accessibility changes;
- A credit check;
- Sufficient medical information to determine whether applicant needs and desires assistance with at least one activity of daily living or instrumental activity of daily living, but does not need assistance that exceeds the limits in 651 CMR 12.04;
- Information to establish GAFC eligibility status, if applicable.

All information will be treated confidentially and will be used only for the purpose described, in accordance with state and federal privacy laws and state and federal laws regarding credit and criminal information.

Once program and tenancy eligibility have been established, Grantham Corporation, or service coordinator, will ask applicant to sign releases to obtain medical information necessary to form a service plan.

I/We hereby certify that the information furnished on this application is true and complete, to the best of my/our knowledge and belief. I/We understand that any false statement or misinformation may result in the cancellation of my/our application and may affect my/our future ability to reside in this Elder CHOICE development. I/We certify that I/We understand that false statements or information are punishable and applicable under state or federal laws.

I/We hereby certify that we have received a notice from Grantham Corporation describing the right to reasonable accommodations for persons with disabilities.

____ ____________________

Head of Household/Applicant Date

____ ____________________

Co-Applicant Date