A Christopher House® Facility

CHRISTOPHER HEIGHTS™ OF WORCESTER

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 _____

E-mail Address :_____Cell _____

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

Name _____

Address _____

Telephone Number: Business _____ Home _____

E-mail Address :_____Cell _____

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 _____

E-mail Address :_____Cell _____

III. Medical information concerning prospective resident:

Primary Physician:

Name _____

Telephone Number _____ Fax 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 _____ Uses an electric scooter _____

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 colostomy/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 intellectually disabled? 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 Assisted Living, 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 (Please list GROSS amounts)

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 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 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 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 Corporation (the provider of all services for Christopher Heights) 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 Corporation 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 management 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