



**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 \_\_\_\_\_

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 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 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.

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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.

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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.*

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Head of Household/Applicant

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Date

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Co-Applicant

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Date