Masonicare

APPLICATION FOR RESIDENCY
Independent Living & Assisted Living

Please complete the following sections of the application:

Section A: **Personal Information** (one for each applicant)

Section B: **Financial Information** (one per couple)

The following documents must accompany the application for financial approval:

- Copies of **two** most recent tax returns (summary pages only)
- Recent bank/investment statements (summary pages only)
- Market value of home

Section C: **Additional Information** (one for each applicant)

Section D: **Physician's Summary** (one for each applicant – **Assisted Living** only)

- Bring this to your primary care doctor(s) for completion
- Completed medical forms must be submitted within 30 days of move-in

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Please return the application to:

Masonicare at Ashlar Village:	Independent Living (CCRC) *$1,350 application fee* Assisted Living (Pond Ridge)	Marketing Department Cheshire Road P.O. Box 70 Wallingford, CT 06492 203-679-6425
Masonicare at Mystic:	Independent Living Assisted Living	Marketing Department 45 Clara Drive Mystic, CT 06355 860-415-2500
Masonicare at Newtown:	Assisted Living (Lockwood Lodge)	Resident Services Coordinator P.O. Box 5505 Newtown, CT 06470 203-364-3179
Masonicare Health Center:	Independent Living (Johnson, Hawkins, Wells Apts.)	Masonicare Services Representative P.O. Box 70 Wallingford, CT 06492 203-679-5402

Thank you for your interest in residency at Masonicare!

Application for Residency

Please select from the following:

- ☐ **Masonicare at Ashlar Village** — Independent Living (CCRC) / Assisted Living (Pond Ridge)
- ☐ **Masonicare at Mystic** — Independent Living / Assisted Living
- ☐ **Masonicare at Newtown** — Assisted Living (Lockwood Lodge)
- ☐ **Masonicare Health Center** — Independent Living (Johnson, Hawkins, or Wells apartments)

SECTION A – PERSONAL INFORMATION

APPLICANT INFORMATION

Name: _____
Last *First* *Middle* *Maiden*

Address: _____
Street *Unit #* *City*

_____ Date of Birth ____/____/____
State *Zip* *Month* *Day* *Year*

Phone: (_____)_____ ☐ Male ☐ Female

Cell Phone: (_____)_____ Religion _____

Email: _____ Church _____

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower

Spouse Name: _____ Date of Spouse's Death: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Primary Contact:

Name: _____ Relationship: _____

Address: _____

Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Email: _____

Secondary Contact:

Name: _____ Relationship: _____

Address: _____

Home: (_____)_____ Cell: (_____)_____ Work: (_____)_____

Email: _____

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SECTION A – PERSONAL INFORMATION

ADVANCE MEDICAL DIRECTIVES

Do you have a **Living Will**? ☐ Yes ☐ No **(Please attach a copy)**

Do you have a **Power of Attorney**? ☐ Yes ☐ No **(Please attach a copy)**

Name: _____ Phone: (_____) _____

Address: _____

Do you have a **Health Care Agent/Representative**? ☐ Yes ☐ No **(Please attach a copy)**

Name: _____ Phone: (_____) _____

Address: _____

Do you have a **Conservator or Guardian**? ☐ Yes ☐ No **(Please attach a copy)**

Name: _____ Phone: (_____) _____

Address: _____

What is his/her relationship to you? _____

INSURANCE INFORMATION

Primary Medical/Medicare Insurance **(Please attach copy of card)**

Company Name: _____ Policy# _____

Address: _____

Secondary Medical Insurance **(Please attach copy of card)**

Company Name: _____ Policy# _____

Address: _____

Prescription Insurance **(Please attach copy of card)**

Company Name: _____ Policy# _____

Address: _____

Long-Term Care Insurance **(Please attach copy of card)**

Company Name: _____ Policy# _____

Address: _____

Soc. Sec. #: _____ Are you eligible for Medicare? ☐ Yes ☐ No

Medicare #: _____

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SECTION B – FINANCIAL INFORMATION

Name(s): _____

Assets:

Real Estate $_____

Other Real Estate $_____

Bank/Investment Accounts:	**Total Account Value**
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

TOTAL ASSETS: $_____

Liabilities:

Mortgage $_____

Other $_____

TOTAL LIABILITIES: $_____

TOTAL NET WORTH: $_____

Net Monthly Income:	*Person 1*	*Person 2*
Social Security	$_____	$_____
Pension/retirement	$_____	$_____
Other	$_____	$_____

TOTAL MONTHLY INCOME: $_____

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SECTION B – FINANCIAL INFORMATION

Long-Term Care Insurance

Do you have Long-Term Care Insurance? Yes ☐ No ☐
If yes, please complete the following:

	Person 1	*Person 2*
Benefit Period (Time limit on payments) (Generally – 1, 2, 5 years or lifetime)	_____	_____
Elimination Period – Waiting time before payments start (ex. 30, 60, 90 days)	_____	_____
Daily benefit in Assisted Living	$ _____	$ _____
Annual Premium (current dollars)	$ _____	$ _____

I (we) hereby agree, upon approval of my (our) application, to make no changes in my (our) financial status that will prevent me (us) from providing my (our) own financial needs while residents.

I (we) declare that all statements made in this application are full, true and correct.

Signature:_____ ***Date***:_____
Person 1

Signature:_____ ***Date***:_____
Person 2

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SECTION C – ADDITIONAL INFORMATION

Military

Are you a military veteran? ☐ Yes ☐ No

Is/was your spouse a military veteran? ☐ Yes ☐ No

What is your claim number? _____ Your spouse's? _____

Masonic Affiliation

Are you or any member of your family a member of a Masonic organization? ☐ Yes ☐ No

What is the name and relationship of that family member? _____

What Lodge/Chapter/Court do you belong to? _____

General Information

Applicant's occupation: (If retired, please indicate this and give former occupation.)

_____

Employed by (last or present employer): _____ Number of years employed: _____

Do you smoke? YES: _____ NO: _____

The information supplied is accurate to the best of my knowledge.

I fully understand that any acceptance for residency at Masonicare is contingent upon my meeting all requirements set by the Board of Directors of Masonicare and there being an accommodation available and agreeable

_____ _____

Signature Date signed

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SECTION D – PHYSICIAN'S SUMMARY

Note to Physician: The person whose name appears below is an applicant for admission to Masonicare. A current health report *is required* as part of the admission process.

Applicant's Name: _____

Date of Birth: _____ Age: _____ Sex: Male ☐ Female ☐

Address: _____

City/State/Zip: _____

Please complete this form and send to: (check one)

Masonicare at Ashlar Village ☐ ***Assisted Living*** **Marketing Department** P.O. Box 70 Wallingford, CT 06492 Tel: 203-679-6425 Fax: 203-679-6044	**Masonicare at Mystic** ☐ ***Assisted Living*** **Marketing Department** 45 Clara Drive Mystic, CT 06355 Tel: 860-415-2500 Fax: 860-415-2443	**Masonicare at Newtown** ☐ ***Assisted Living*** **Resident Services Coordinator** P.O. Box 5505 Newtown, CT 06470 Tel: 203-364-3179 Fax: 203-364-3299

Purpose of Assessment: ☐ Pre-Admission Date of Examination: _____

Primary diagnosis + ICD-9 code: _____

Secondary: + ICD-9 code: _____

☐ PPD ☐ Chest X-Ray Date Received: _____ Result: ☐ None/Inactive ☐ Active/Quiescent

If contraindicated, state reason: _____

Physical Health:

Weight _____ Height _____ Blood Pressure _____

Pulse _____ Respiration _____

Functional Abilities:	Good	Fair	Poor	Additional Information
Walking (with/without device)	☐	☐	☐	
Hearing (with/without device)	☐	☐	☐	
Vision (with/without corrective lenses)	☐	☐	☐	
Speech	☐	☐	☐	

Activities of Daily Living:	Self	Assistance Required	Additional Information
Bathing	☐	☐	
Personal Hygiene	☐	☐	
Dressing	☐	☐	
Toileting/Toilet Hygiene	☐	☐	
Transferring (bed to chair/chair to bed)	☐	☐	
Oral Hygiene/Denture Care	☐	☐	
Eating at meal time	☐	☐	

Medication Use:	Yes	No	Additional Information
Does resident administer own medications?	☐	☐	
Does resident require medication reminder?	☐	☐	
Does resident require supervision when taking medications?	☐	☐	

Lifestyle:	Yes	No	
Does the resident smoke?	☐	☐	
Does the resident consume alcohol?	☐	☐	

Mental Health:

Cognitive Status ☐ Alert ☐ Short-term memory concerns
☐ Confused ☐ Long-term memory concerns

Evidence of Dementia ☐ Yes ☐ No Type if known: _____

History of Mental Illness/Health Problems: ☐ Yes ☐ No

Diagnosis, if known _____

Medical History: *If yes, give details. Use additional sheet if necessary.*

Arthritis	☐ Yes	☐ No	Hematological Disorders	☐ Yes	☐ No
ASHD	☐ Yes	☐ No	Hepatic Pathology	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Cerebral Arteriosclerosis	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No
Cerebral Vascular accident	☐ Yes	☐ No	Neurological Disease	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Developmentally Disabled	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pulmonary Disease	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	Renal Pathology	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Family or other history of HIV	☐ Yes	☐ No	TBC	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No			

Other: _____

Details: _____

_____

Allergies: ☐ Yes ☐ No Explain: _____

Review of Systems:

Integumentary

Respiratory

Cardiovascular

Gastrointestinal

Genitourinary

Musculoskeletal

Neurological

Endocrine

Pain

Prescription Medications:

Medication	Dosage	Frequency by time	Additional Information

OTC Medications:

Medication	Dosage	Frequency by time	Additional Information

Other Supplements/Treatments: (i.e. Holistic/Natural/Homeopathic/Massage etc.)

Medication	Dosage	Frequency by time	Additional Information

Special Treatments and Procedures, not listed above (Narrative): _____

_____

_____

Routine Orders:

Routine Lab Work ☐ Yes ☐ No

Test(s) _____ Frequency _____

Test(s) _____ Frequency _____

Test(s) _____ Frequency _____

Podiatry Services ☐ Yes ☐ No Frequency _____

Annual Flu Vaccine ☐ Yes ☐ No Date last received _____

Other _____

Specific Diet Requirements ☐ Regular ☐ No added salt ☐ Diabetic

☐ Other _____

IMPORTANT

In your medical opinion, is the resident considered chronic and stable? ☐ Yes ☐ No

Does the applicant have a signed Do Not Resuscitate Order (DNR)? ☐ Yes ☐ No

Would you recommend the applicant for a campus-sponsored fitness program? ☐ Yes ☐ No

Are there any restrictions to consider?

Explain: _____

Physician's Name _____ *(type or print)*

Physician's Address _____ City/State/Zip _____

Telephone/FAX _____

Signature of Physician _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL

I hereby authorize the release of medical information contained in the report of the examination of:

Applicant Name: _____

Signature: _____ **Date:** _____