



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

Please return the application to:

Masonicare at Ashlar Village:	Independent Living (CCRC) <i>\$1,350 application fee</i>	Marketing Department Cheshire Road P.O. Box 70 Wallingford, CT 06492 203-679-6425
	Assisted Living (Pond Ridge)	
Masonicare at Mystic:	Independent Living Assisted Living	Marketing Department 23 Clara Drive Mystic, CT 06355 860-543-4529
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!

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: _____

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 #: _____

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: \$ _____

Long-Term Care Insurance

Do you have Long-Term Care Insurance? <i>If yes, please complete the following:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	<i>Person 1</i>	<i>Person 2</i>
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

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

This page intentionally left blank for double-sided copying.

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 <i>Assisted Living</i> Marketing Department P.O. Box 70 Wallingford, CT 06492 Tel: 203-679-6425 Fax: 203-679-6044	Masonicare at Mystic <i>Assisted Living</i> Marketing Department 23 Clara Drive Mystic, CT 06355 Tel: 860-543-4529 Fax: 860-572-0021	Masonicare at Newtown <i>Assisted Living</i> Resident Services Coordinator P.O. Box 5505 Newtown, CT 06470 Tel: 203-364-3179 Fax: 203-364-3299
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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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing (with/without device)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision (with/without corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Activities of Daily Living:	Self	Assistance Required	Additional Information	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Toileting/Toilet Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Transferring (bed to chair/chair to bed)	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Oral Hygiene/Denture Care	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Eating at meal time	<input type="checkbox"/>	<input type="checkbox"/>	_____	

Medication Use:	Yes	No	Additional Information
Does resident administer own medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does resident require medication reminder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does resident require supervision when taking medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Lifestyle:	Yes	No	
Does the resident smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does the resident consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Mental Health:			
Cognitive Status	<input type="checkbox"/> Alert	<input type="checkbox"/> Short-term memory concerns	
	<input type="checkbox"/> Confused	<input type="checkbox"/> Long-term memory concerns	
Evidence of Dementia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type if known: _____
History of Mental Illness/Health Problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Diagnosis, if known _____

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

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

Other: _____

Details: _____

Allergies: Yes No Explain: _____

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:** _____