New Horizons
This is home!

APPLICATION FOR RESIDENCY

CHOATE-Woburn
- ☐ Independent Living
- ☐ Assisted Living

MARLBOROUGH
- ☐ Independent Living
- ☐ Full Service Retirement
- ☐ Assisted Living

We are pleased that you wish to join our New Horizons community! To arrange for accommodations, it is necessary that you first complete this Application for Residency and submit it with a $300 Application Fee payable to *New Horizons*. This application, in combination with the physician's statement and an interview with an admissions committee member, will assist us in determining approval. We look forward to hearing from you soon and to your joining this wonderful retirement community.

GENERAL (one application per person)

Applicant's Name: _____ Email: _____

Birth Date: _____ Birth Place: _____ Current/former occupation: _____

Permanent Address: _____
(Street) (City, State and ZIP)

Present Address (if different): _____

How long at present address? _____ Telephone: (h)_____ (cell)_____

Marital Status: _____ Veteran: Yes ☐ No ☐ Spouse of Veteran: Yes ☐ No ☐

FINANCIAL

Assets (couples may complete *jointly* on one application)

Bank Account(s)	$_____
Certificates of Deposit	$_____
Stocks & Bonds, etc.	$_____
Real Estate	$_____
401(k) / IRA	$_____
Other Major Assets*	$_____
TOTAL ASSETS	$_____

Liabilities (couples may complete *jointly* on one application)

Home Mortgage	$_____
Other Loans*	$_____
TOTAL LIABILITIES	$_____

*Please describe on a separate page

TOTAL NET WORTH (Assets minus Liabilities) $_____

Monthly Income (couples shall complete *separately*)

Employment Income	$_____ per month	Interest Income	$_____ per month
Social Security Income	$_____ per month	Rental Income	$_____ per month
Pension Income	$_____ per month	Other _____	$_____ per month
Family Assistance	$_____ per month	**TOTAL INCOME**	$_____ per month

AGENTS and GUARANTOR (required of all applicants)

Name and address of *Guarantor*:

Name: _____ Email: _____

Address: _____ Phone: _____
(Street) (City, State and ZIP)

Name and address of *Power of Attorney*:

Name: _____ Email: _____

Address: _____ Phone: _____
(Street) (City, State and ZIP)

Name and address of *Health Care Agent*:

Name: _____ Email: _____

Address: _____ Phone: _____
(Street) (City, State and ZIP)

Name and address of *Billing Party (if other than self)*:

Name: _____ Email: _____

Address: _____ Phone: _____
(Street) (City, State and ZIP)

HEALTH -- SELF-ASSESSMENT

1. Do you live alone? Yes: _____ No: _____
2. Do you smoke? Yes: _____ No: _____
3. Is it helpful when family or friends check in with you frequently throughout the day? Yes: _____ No: _____
4. Do you require others to prepare meals for you? Yes: _____ No: _____
5. Do you require others to assist you with your medications by:
   a. reminding you to take medication? Yes: _____ No: _____
   b. filling weekly medication cassettes for you? Yes: _____ No: _____
   c. arranging for prescription refills? Yes: _____ No: _____
6. Do you currently take medication that helps with your memory? Yes: _____ No: _____
7. Do you feel unsteady or unsafe in the bathroom at times? Yes: _____ No: _____
8. Is it helpful for you to have someone assist you with toileting? Yes: _____ No: _____
9. Is it helpful to use a walker and/or a wheelchair to get around? Yes: _____ No: _____
10. Have you had a fall in the past six months? Yes: _____ No: _____

    If yes, please describe: _____

LEVEL OF DAILY ACTIVITY

	Good	Fair	Poor		Good	Fair	Poor		Good	Fair	Poor
Housekeeping	_____	_____	_____	Exercise	_____	_____	_____	Shopping	_____	_____	_____
Taking medication	_____	_____	_____	Walk unassisted	_____	_____	_____	Laundry	_____	_____	_____
Fire awareness	_____	_____	_____	Transportation	_____	_____	_____	Budgeting	_____	_____	_____

PRIMARY CARE PHYSICIAN

Name: _____ Email: _____

Address: _____ Phone: _____

ADDITIONAL INFORMATION

Past/present clubs, civic involvement, etc: _____

Personal strengths and interests: _____

_____

I understand and agree that the foregoing application is not a contract or reservation for residence at New Horizons and that nothing contained herein is binding on any party until a Residence Agreement has been signed by the parties hereto. I certify that the information which I have provided in this Application for Residence is true and correct to the best of my knowledge and belief as of the date hereof. I authorize you to make any necessary inquiries for the purpose of verifying this or any other information provided. I further agree to promptly notify the Executive Director in the event of any material financial change hereto. These statements are made under the penalties of perjury.

Date: _____ Signed: _____
Applicant (or Authorized Representative)

(New Horizons Use Only)				
Interviewer:	Date:	Physician's Stmt Rec'd:	Fee Paid:	Approval Date:

New Horizons
This is home!

PHYSICIAN'S STATEMENT

Woburn ☐ Marlborough ☐

I, _____, hereby authorize and request my physician, _____, to release and furnish all information regarding my medical history and current medical status to New Horizons, in conjunction with my application for residency at that facility. I further authorize any other health care providers and facilities to release future health care records and related information to New Horizons' Executive Director.

_____ _____

Date Applicant (or Authorized Representative)

Please print clearly to expedite this application process.

Applicant's name:_____ Date of birth:_____

Note to physician: Your patient has applied for entrance to our New Horizons senior community, which offers a continuum of programs, including:

(1)* **Apartment-style independent living** – includes one meal daily, with an option for another meal, at additional cost; living accommodation is a typical apartment with full kitchen in multi-story buildings.

(2) **Independent living with hospitality services** – includes three meals daily, plus light housekeeping and linen laundering; suite living accommodation includes kitchenette.

(3) **Assisted living** – includes same services as (2), plus access to home health aides for assistance with activities of daily living at additional cost, e.g. bathing, dressing, escorts to meals and activities, etc.

(4) **Alzheimer care wing** – a secure facility, independently operated, offering the same services as (2), plus special care services tailored to individuals living with Alzheimer's or related dementias.

(5)* **Mental health enhanced care unit** – a secure facility, independently operated, offering the same services as (2), plus special care services tailored to individuals suffering from conditions such as acute anxiety disorder or depression.

* Programs (1) and (5) are available at the Marlborough facility only.

Neither facility (Woburn or Marlborough) provides long-term nursing care or skilled nursing services. Please keep these factors in mind as you evaluate your patient's present physical and mental health. If any answer herein requires additional space, please feel free to supplement this form.

Once completed, this form must be received by New Horizons before any action can be taken on the application. Thank you in advance for your vital, timely assistance. Please **mail** or **fax** this form to whichever facility is indicated above:

New Horizons at Choate, LLC ▪ **21 Warren Avenue** ▪ **Woburn, MA 01801** ▪ **fax: 781-938-8355**

New Horizons at Marlborough, LLC ▪ **400 Hemenway Street** ▪ **Marlborough, MA 01752** ▪ **fax: 508-460-7682**

Present health status:_____

_____

Allergies:_____

Special diet:_____

Current medications:_____

_____

Medical history:_____

_____

_____

Recent hospitalizations (last five years) and diagnoses:_____

_____

_____

Is Applicant able to independently and accurately follow your prescribed medical regime?_____

Comments:_____

_____

Is Applicant able to independently perform the activities of daily living?_____

Comments/limitations:_____

Does Applicant use a walker? _____ Cane? _____ Wheelchair? _____

If wheelchair is used, can Applicant transfer on his/her own? _____

Does Applicant have difficulty with stairs?_____

Is Applicant oriented as to: Time?_____ Place?_____ Person?_____

Does Applicant have appropriate behavior patterns?_____

Please answer yes or no if Applicant has or has had a history of any of the following diseases or disorders.

Angina:_____	Asthma:_____	Sensory deficits:_____	Epilepsy/seizures:_____
Arrhythmia:_____	COPD:_____	Visual:_____	Parkinson's:_____
CHF:_____	Arthritis:_____	Auditory:_____	Dementia:_____
Hypertension:_____	Osteoporosis:_____	Speech:_____	Anxiety:_____
MI:_____	Alcohol abuse:_____	Cancer:_____	Depression:_____
CVA:_____	Drug abuse:_____	Eating disorder:_____	Decubiti/skin cond.:_____
Emphysema:_____	Incontinence:_____	Diabetes:_____	Communicable disease:_____

If you answered yes to any of the above, please supply supplemental information including dates and prognosis:

_____

_____

_____

Will you continue to follow Applicant after his/her move to New Horizons? _____

General comments:_____

_____

Immunization (dates): Tetanus:_____ Influenza:_____ Pneumococcal:_____

Per CDC guidelines, all applicants must have a tuberculosis screening within 90 days prior to move-in:

Mantoux Test Results:	Step 1	Negative _____mm	Positive _____mm	Date _____
	Step 2	Negative _____mm	Positive _____mm	Date _____
X-ray results: Date _____	☐ Normal ☐ Non-active TB Infection	☐ Abnormal/TB	☐ No TB Infection ☐ TB Suspect	

I recommend this applicant for residence at New Horizons:

- ☐ (1) **Apartment-style independent living** (*Marlborough only*)
- ☐ (2) **Independent living with hospitality services**
- ☐ (3) **Assisted living**
- ☐ (4) **Alzheimer care wing**
- ☐ (5) **Mental health enhanced care unit** (*Marlborough only*)

Physician's name:_____ Signature:_____ Date:_____

Address:_____ Phone (____)_____