



## **PRELIMINARY APPLICATION FOR THE HERITAGE PROGRAMS**

### **Our Mission and Resident Evaluations**

Heritage at Framingham is a not for profit assisted living community within Mary Ann Morse Healthcare Corp. Our mission is to serve each accepted applicant with the highest level of care within either of our two programs.

### **Programs Matched to Current & Changing Needs**

The preliminary application process determines the starting point of care within our programs. Each is designed to support physical, cognitive, social and dietary needs at appropriate levels.

If needs change, our team will determine appropriate strategies or placement. Our team includes nurses, care aids, activity leaders and program directors. We also team up with a geriatric MD, PCPs, visiting nurses and physical therapists. Our observations are used to create and update individualized service plans and care approaches.

### **Programs Outlined**

Resident Needs	PROGRAMS & PROVISIONS	
	Classic	Homestead
<b>Physical</b>	Aid with Activities of Daily Living (ADL's), medication management, incontinence.	Aid with Activities of Daily Living, medication management, incontinence, encouragement & cueing for participation
<b>Care Time</b>	Up to 45 minutes per day	Up to 2 hours per day
<b>Cognitive</b>	No to little cognitive issues	Early, mid and later stage cognitive loss
<b>Social</b>	Residents pick and choose activities. Some encouragement provided	Residents can choose activities. Moderate to high level of encouragement or cueing.
<b>Environment</b>	Access is independent on and off campus	Access is "low to high" supervision on campus as needed and high supervision off campus.

### **Movement Across Programs For the Benefit of Residents**

Our mission guides decisions and advocates for resident care. Families will be informed of any recommended or anticipated program changes in a timely manner and we will work to educate families on program benefits. Family input is welcome and encouraged at all times.

### **Preliminary Acceptance Process**

Preliminary acceptance is based on appropriateness for a particular program after successful completion of the following steps:

- Preliminary Background Data on pages 2 and three of this document
- Medical Release form sent to Primary Care Physician and returned
- Screening by one of our nurses; who will evaluate physical, cognitive, dietary, medical and social needs.
- Financial form required – pre planning is an important consideration

Willing family cooperation and input are also helpful and are encouraged for the benefit of each resident.

**KEEP THIS PAGE FOR YOUR RECORDS  
PLEASE COMPLETE & RETURN THE FOLLOWING TWO PAGES**

**PRELIMINARY APPLICATION INFORMATION**

**I. GENERAL INFORMATION**

Applicant Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How Long at this address? \_\_\_\_\_ yrs. Contact Phone # \_\_\_\_\_ Birth Date: \_\_\_ / \_\_\_ / \_\_\_

Birth Place: \_\_\_\_\_ Gender: Male Female Current or former occupation: \_\_\_\_\_

Marital Status: (Circle one) Married Single Widow/er Divorced Separated

**In an emergency, who should we call?**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name of **Power of Attorney**: \_\_\_\_\_ or **Guardian**: \_\_\_\_\_

Name of **Health Care Proxy**: \_\_\_\_\_

*[Please attach documentation for Power of Attorney, Guardian or Health Care Proxy if they exist.]*

**II. CURRENT LIVING SITUATION** **Check one:**  Own my home  Renting

**Check one:**  Apartment  Single Family  Multi-family  Condo

If renting, monthly rental \$ \_\_\_\_\_ Owner /Landlord: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Do you own a car?** Yes  No  **Make & Year:** \_\_\_\_\_

Do you drive regularly? Yes  No  Do you intend to maintain a car? Yes  No

Are there any problems or concerns which our staff should be aware of, or any special support you might need to live in our community? \_\_\_\_\_

Do you require someone (friend, relative, or other) to live with you at the present time? Yes  No

If so, who: \_\_\_\_\_ Reason for this need? \_\_\_\_\_

If not, do you require someone to visit you during the day? Yes  No

If yes, reason for a visit? \_\_\_\_\_ How long is a visit? \_\_\_\_\_

Are you considering other housing options? Yes  No  If so, which? \_\_\_\_\_

**III Medical and Insurance Information**

Physician's name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Hospital Affiliation: \_\_\_\_\_

How would you describe your present state of health? \_\_\_\_\_

How often do you see your doctor? \_\_\_\_\_ When was your last visit? \_\_\_\_\_

How much walking do you do? \_\_\_\_\_ Any difficulty with stairs? Yes \_\_\_ No \_\_\_

Please check off any of the following that you use: Cane , Walker , Wheel chair

Are you on any medications at the present time? Yes  No  If yes, please specify the medication and condition being treated: \_\_\_\_\_

\_\_\_\_\_ Use reverse side if needed.

Do you require assistance to administer the medication? Yes  No

Do you prepare your own meals? Yes  No  If no, who? \_\_\_\_\_

Are you on a special/restricted diet? Yes  No  If yes, describe \_\_\_\_\_

Please list all of your medical insurance coverage's, including supplemental health insurance:  
Medicare \_\_\_\_\_ Policy #-required: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Policy #-required: \_\_\_\_\_

**IV. Daily Living** Please use an "X" to indicate your ability for the tasks listed below:

TASK	"I can handle myself"	"I need some assistance"	COMMENTS
Bathing			
Dressing			
Mouth or Skin Care			
Shaving or Grooming			
Toileting			
Escort/Mobility			
Med Reminder			
Night Care			
Housekeeping			
Clothing Management			

What are your personal strengths and interests? \_\_\_\_\_

How do you like to spend your time? \_\_\_\_\_

Is there any other information we should be aware of when reviewing your health and medical concerns? \_\_\_\_\_

I understand and agree that *this application is neither a contract, nor a reservation for residence.* Nothing contained in this document is legally binding for me or the community to which I am applying for residency, until a Residency Agreement has been approved and signed by all parties involved.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Application

8.23.10

**Completion of this section is voluntary.** In order to help us carry out our responsibilities under applicable Fair Housing Laws, we ask that you identify yourself by one of the following designations: (Please circle only one)  
WHITE BLACK ASIAN AMERICAN INDIAN OTHER