



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
Physical	Aid with Activities of Daily Living (ADL's), medication management, incontinence.	Aid with Activities of Daily Living, medication management, incontinence, encouragement & cueing for participation
Care Time	Up to 45 minutes per day	Up to 2 hours per day
Cognitive	No to little cognitive issues	Early, mid and later stage cognitive loss
Social	Residents pick and choose activities. Some encouragement provided	Residents can choose activities. Moderate to high level of encouragement or cueing.
Environment	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

12.13.10

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