APPLICATION

CARMEL TERRACE
— ASSISTED LIVING —

The Difference is Love

RESIDENT INFORMATION

DATE _____

NAME _____

CURRENT ADDRESS _____
(Street)

_____
(City) (State) (Zip Code)

PHONE_____HOW LONG AT ABOVE ADDRESS?_____

DATE OF BIRTH _____ PLACE OF BIRTH_____

HOW DID YOU HEAR ABOUT US?_____

DO YOU OWN YOUR HOME? Yes____ No _____ U.S. CITIZEN? Yes____ No____

MARITAL STATUS: Single_____ Married_____ Widowed _____ Divorced_____

NAME OF SPOUSE _____

ARE YOU/SPOUSE A VETERAN? Yes____ No____ RETIRED? Yes_____No_____

WHAT IS/WAS YOUR OCCUPATION? _____

WHAT IS/WAS YOUR SPOUSE'S OCCUPATION? _____

POWER OF ATTORNEY: _____
(Name)

_____
(Street) (City) (State) (Zip Code)

HOME PHONE: _____ RELATIONSHIP_____

WORK PHONE: _____ EMAIL:_____

DO YOU HAVE AN ATTORNEY? _____
(Name)

_____
(Street) (City) (State) (Zip Code)

Telephone _____

PERSON(S) TO CONTACT IN AN EMERGENCY:

Name _____

Address _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ Relationship to you: _____

Work Phone: _____ Email: _____

PERSONAL IDENTIFICATION NUMBERS:

Social Security # _____ Military I.D. # _____

Medicare # _____ Medex # _____

Other Health Insurance _____

Please give a brief summary of your health background (including hospitalizations) and current status:

_____

_____

_____

PRIMARY PHYSICIAN _____

ADDRESS _____
(Street) (City) (State) (Zip Code)

Telephone _____ Fax _____

OTHER PHYSICIAN _____

ADDRESS _____
(Street) (City) (State) (Zip Code)

Telephone _____ Fax _____

Carmel Terrace

933 Central Street
Framingham, MA 01701

FINANCIAL INFORMATION

In order for Carmel Terrace to protect both the organization and its residents, we need sound financial planning. It is necessary for us to know about the resources of future residents. This information will be kept in the strictest confidence.

Name _____ Date _____

SOURCE	MONTHLY INCOME
Social Security	$ _____
Pension	$ _____
Annuity	$ _____
Trust Accounts Approximate Value $_____	$ _____
Other _____	$ _____

ASSETS

	Approximate Capital Value	Annual Income
Stocks	$_____	$_____
Savings	$_____	$_____
Certificates	$_____	$_____
Bonds	$_____	$_____

Please indicate which of the following are subject to cost of living increases:

Pensions _____

Annuities _____

Trusts _____

Rentals _____

Other (Please describe) _____

CHECKING ACCOUNTS	Account #	Average Balance
Bank _____	_____	$_____
Bank _____	_____	$_____

REAL ESTATE (in applicant's name or in joint ownership)

Location	Approximate Market Value
_____	$_____
_____	$_____

LIFE INSURANCE POLICIES (on applicant's life or owned by applicant)

Company	Policy #	Face Value	Cash Value
_____	_____	$_____	$_____
_____	_____	$_____	$_____

Any other sources of income (describe)_____

_____

Any debts, mortgages, obligations affecting the income or assets_____

_____

I affirm the foregoing is a true statement of facts known to me and is submitted for this application for residency at Carmel Terrace.

Signature _____ Date _____

Name_____

CARMEL TERRACE QUESTIONNAIRE

To help us get acquainted, please check the appropriate box for each question.

1. Ambulation
Do you walk with the aid of a device? No___ Yes__ If yes, which device?

a. Cane_____ c. Walker_____

b. Quad Cane_____ d. Use Wheelchair for mobility_____

2. Do you require supervision or assistance with walking?

a. One person supervision_____

b. Physical Assistance (holding onto someone's arm)_____

c. No assistance needed_____

3. Have you had a fall in the past year which resulted in:

a. Seeking medical attention_____

b. A fracture (i.e., broken hip, leg, arm or fracture of other body part)_____

c. A wound requiring stitches_____

4. Do you become short of breath when you:

a. Exercise_____

b. Walk_____

c. Are at rest_____

d. All of the above_____

5. **Do you currently use an inhaler or nebulizer regularly, or on an "as-needed" basis?**

   a. Yes, Inhaler_____

   b. Yes, Nebulizer_____

   c. Both – Inhaler and Nebulizer_____

   d. None of the above_____

6. **Do you currently use Oxygen regularly or on an "as-needed" basis?**

   Yes_____

   No_____

7. **Are you currently taking Coumadin or any other blood thinner?**

   Yes_____

   No_____

8. **Are you an insulin-dependent diabetic?**

   Yes_____

   No_____

9. **Have you been hospitalized in the past five years for any physical or mental illness?**

   Yes_____ If Yes, Date of Hospitalization_____

   Reason for Hospitalization_____

   No_____

10. Are you currently taking medications for:

_____ High blood pressure

_____ Depression

_____ Diabetes

_____ Anxiety

_____ Panic Disorder

_____Anemia

_____ Bipolar Disorder

_____ Seizures

11. Please list all medications you currently take on a daily, or "as-needed" basis. (You may ask your pharmacist for a print-out of your medications).

_____

_____

_____

12. Are you allergic to any medications?

Yes_____ If Yes, please specify_____

No known allergy to medications_____

13. Do you have an allergy to any foods?

Yes_____ If Yes, please list_____

No known allergy to any foods

14. Do you wear a hearing aide to help you hear?

Yes_____ Left ear_____ Right ear_ Both ears_____

No_____

15. Are you legally blind?

Yes_____ No_____