BROAD REACH
VICTORIAN ASSISTED LIVING

The Victorian Assisted Living Residence
Resident application

Name _____ Date of birth _____

Street _____ Town/City _____

State _____ Zip _____ Phone _____

Current Medical Diagnosis _____

_____

Physical Health Limitations _____

_____

Height _____ **Weight**_____ Has there been a significant weight change in the past six months? ❑Yes ❑No

If 'Yes', please explain _____

_____

Mental Health Limitations _____

_____

Medication ❑Self administered
❑Needs assistance with self administration
❑Needs medication administered by licensed nurse

Treatments/Therapies ❑Respiratory ❑Physical ❑Occupational ❑Speech ❑Hearing

Comments_____

Diet Can diet be met with regular diet? ❑Yes ❑No

If 'No', list dietary requirements _____

_____

Does this individual's health status require continuous nursing care or convalescent care for more than seven (7) consecutive days? ❑Yes ❑No

If 'Yes', this individual's health status is not appropriate for Assisted Living care without supplemental services.

Signature: _____ **Date:** _____

Eating	❑ No assistance required	❑ Chokes easily	❑ Swallowing problems
	❑ Problems chewing	❑ Minor assistance required	❑ Assistance with entire meal

Ambulation	❑ Independent with/without device	**Type of Device**	❑ Wheelchair
	❑ Unsteady Gait		❑ Walker
	❑ Walks with continuous human support		❑ Crutches/Cane
	❑ Bed to chair - total help		❑ Other_____
	❑ Bedfast		❑ N/A
	❑ Falls frequently due to_____		

Wheelchair Use	❑ Independent	❑ Unable to transfer
	❑ Assistance with difficult maneuvering	❑ N/A
	❑ Wheels a few feet	

Bladder Control	❑ Continent ❑ Occasional incontinence (Once a week or more and able to handle occurrences independently or with assistance) ❑ Frequent Incontinence ❑ Total Incontinence	**Bowel Control**	❑ Continent ❑ Total Incontinence ❑ Ostomy
Hearing (with or without devices)	❑ Good ❑ Limited (must speak loudly) ❑ Virtually/Completely deaf ❑ Uses aid appropriately ❑ Identify aid _____ _____	**Communicates**	❑ All needs well met ❑ Limited (must speak loudly) ❑ Special device or specially trained staff required to communicate ❑ Explain _____ _____
Bathing	❑ Tub ❑ No assistance required ❑ Shower ❑ Supervision only ❑ Sponge bath ❑ Assistance required ❑ Must be bathed	**Dressing**	❑ Dresses Self ❑ Minor assistance needed ❑ Partial assistance needed ❑ Total assistance needed

Sight	(with/without glasses) ❑ Good	❑ Adequate	❑ Unable to read - see details	
	❑ Vision limited --gross object deferential	❑ Blind	❑ Uses aid consistently and appropriately	
	Identify aid_____			

Can this individual's needs be met in a living environment for adults which provides medical stand-by assistance only? ☐ Yes ☐ No

Assessment completed by _____ Assessment date _____

Financial Information Worksheet

Applicant's name: _____ Spouse's name _____

Joint statement: ❑ Yes ❑ No

In order to process your application we need to verify a source of payment and ability to pay for the applicant's care. Please make sure all information is complete and accurate as discrepancies will delay processing.

Health Benefits (*Please include copies of insurance cards with worksheet*.)

Medicare # _____ MassHealth _____

Other Insurance (name & policy#) _____

Med D/Rx Plan # _____

Long Term Care Insurance _____

Cash Assets

Name of Institution	Acct. #	Savings/ Checking	Balance	As of date

Income (Applicant's only or Joint - list both & identify)

Income Sources	Please list names	Amount	Total Yearly
Social Security		$ per month	$
Pensions		$ per month	$
Annuities		$ per month	$
Trusts (check one) ❑Revocable ❑Irrevocable		$ per month	$
Rental		$ per month	$
Dividends		$ per month	$
Interest		$ per month	$
Bonds		$ per month	$
Other (describe-->)		$ per month	$
Other (describe-->)		$ per month	$
Totals			**$**

Please note any time (or lifetime) limits on pensions, annuities, trusts, etc.

_____

_____

Applicant's Assets:		Life Insurance Policies (on applicant's life or owned by applicant):	policy #1	policy #2
Equity in Residence	$	Company		
Savings & C.D.'s	$	Policy #		
Stocks	$	Face Value:	$	$
Bonds	$	Cash Value	$	$
Other R. E. Equity	$	List any other sources of income or assets below:		
Other_____	$			
Other_____	$			
Total Assets	$			

1. Are there any debts, mortgages, obligations, etc. affecting the income or assets? ❑Yes ❑ No If yes, please explain.

_____

2. For the purposes of this transaction, must your present home be sold? ❑ Yes ❑ No

3. Will you need to arrange for a short-term loan with your bank to complete this transaction? ❑Yes ❑ No

4. Does your pension (income) cease when you die? ❑Yes ❑ No If no, does it continue to go to your spouse? ❑Yes ❑No

5. Does your pension increase with the cost of living? ❑Yes ❑ No

Transfer of Assets

Has any of the applicant's owned or jointly-owned real estate, personal property, cash or other assets been transferred, sold, or given as a gift in the last 60 months? ❑Yes ❑No

Item transferred	Value	To Whom	Date

Your attorney:_____

Address: _____ Phone _____

Power of attorney, held by whom:_____

Address: _____ Phone _____

Financial Advisor: _____

Address: _____ Phone _____

I certify to the best of my knowledge, that the above statements are true. I agree to submit documentation, including without limitation, copies of bank records for all assets, debts and other information provided above, if requested. I authorize you to conduct a credit review of my financial institutions named above. I also understand that the Facility considers this application for residence to be a continuing statement of my financial condition, and I agree to notify the Facility in writing of any substantial change in my financial condition. The Facility agrees to keep all information contained here, and provided in the future, strictly confidential.

Applicant or financially responsible party: _____ Relationship to Applicant: _____

Signature: _____ Date: _____