mary's meadow
AT PROVIDENCE PLACE

I am interested in living at Mary's Meadow

I. Personal Information:

Name:_____

Maiden Name: _____

Tel. No: _____

Mailing Address:_____

_____

Legal Address (if different from above): _____

_____

Social Security Number: _____

Citizen of U.S.: Yes No Years in the U.S:_____

If naturalized, certificate #_____.

Date of Birth:_____Place of Birth: _____

Marital Status (Please check.): ___ Single ___ Married ___Widowed

Spouse's Name: _____

If you have any children please list:

Name: Address: Tel. No:

_____

_____

_____

Name and address of person designated to act on your behalf in the event you are incapacitated at any time during your tenancy:

_____

_____

_____

II. Current Living Situation:

Do you own your own home, or rent? (Circle one.) Own Rent

What type of housing do you live in? (Circle one.)
Apartment Single Family Multi-family Condo Other

Which statement best describes your current living situation? (Please circle one response only.)

1. Living alone
2. Living with spouse
3. Living with an adult child
4. Living with a brother, sister, or other relative
5. Living with a friend
6. Other (Please describe): _____

_____

Do you own an automobile? Yes No
If yes, number of cars owned: ____

Do you drive yourself regularly? Yes No

III. Insurance and Medical Information:

Please provide the following information:

Social Security **#:**_____ Medicare**#:**_____
Medex**#:**_____ Medicaid**#:**_____
Blue Cross/Blue Shield Number:_____
Address:_____

Other Health Care Insurance
General Medical Coverage (Name and type of coverage):

_____

_____

_____

Long Term Care Insurance
(Name and type of coverage, if any):
Company:_____
Monthly premium: _____

Life Insurance
Company:_____
Face value: $_____
Monthly premium: $_____

Prepaid Funeral Arrangements
Funeral Home:_____ Tel. #:_____
Address:_____

I hereby certify to the best of my knowledge and belief, that the above information is true, correct, and complete. I understand that if any information has been falsely represented, this will be sufficient cause for voiding my application, and for my removal from the facility.

Resident Signature:_____ Date:_____

Responsible Party's Signature:_____Date:_____

III. Insurance and Medical Information (continued):

Primary Care Physician's Name:_____Tel. No: _____
Address: _____

_____

How often do you see your doctor? _____
When was your last visit? _____
Are you on any medication(s) at the present time? Yes No
If yes, please specify the medication(s) and condition(s) being treated:

_____

_____

_____

_____

_____

_____

Do you prepare your own meals? Yes No
If no, who does?_____
Are you on a special or restricted diet? Yes No
If yes, please describe:_____

_____

Do you use any assistance such as a cane, walker or wheelchair? Yes No
If yes, please specify:_____
Do you have difficulty with stairs? 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? _____

_____

_____

Special Medical Authorization

This authorizes the facility to request any of my medical information from any doctor, hospital, clinic or nursing home or other healthcare provider to which I am or have been known. This authorization includes psychiatric history and treatment, as well as any other form of medical treatment, medical of nursing history, or care received.

_____

Signature of Applicant

_____

Or Signature of Responsible Agent

Witnessed by:

_____

Name

_____

Date

As a member of the Sisters of Providence Health System, this facility does not discriminate on the basis of race, color, age, national origin, religion, creed, sex, handicap or veteran's status in admission or access to or treatment or employment in its programs or activities. The facility will abide with the following rules and regulations.

- Title VI of the Civil Rights Act of 1964 (43 U.S.C. 2000D ET. SEQ.); 45 C.F.R., Part 80.
- Section 504 of the Rehabilitation Act of 1973, as amended, (20 U.S.C. 794); 45 C.F.R., Part 84.
- Age Discrimination Act of 1975, as amended, (41 U.S.C. 6101 ET SEQ.), 45 C.F.R. Part 91.

The Vice President of Human Resources is the designated Section 504 coordinator empowered to assure compliance with the Civil Rights Law at Sisters of Providence Health System. You may contact her/him for further information about these laws and the grievance procedure available for the resolution of discrimination complaints

IV. Daily Living:

Please use an "X" to indicate your level of ability in the following areas:

Task	Completely Independent	Some Assistance Needed	Comments
Preparing meals			
Housekeeping			
Laundry			
Bathing			
Fire Safety			
Budgeting			
Shopping			
Transportation			
Dressing			
Medications			
Walking			

V. Inquiry Information:

How did you find out about Mary's Meadow?

(Please place an "X" next to *all* the categories which apply.)

_____1. I was referred by (Please print name of person, party, or organization which referred you.): _____

_____2. I attended an educational seminar at Providence Place.

_____3. I received written information in the mail.

_____4. I received a phone call.

_____5. I responded to an ad which appeared in the (Please state the name of paper or publication which ad appeared in.): _____

_____6. I attended an Open House.

_____7. I heard a radio ad.

_____8. Other (Please explain.): _____

_____

In the space provided below, please state in your own words, the three major reasons why you have chosen Mary's Meadow as a possible future place to live.

1. _____

_____

2. _____

_____

3. _____

_____

Your occupation (past or present): _____

Highest level of education achieved: _____

Please list any hobbies, community or other special interests:

_____

_____

_____

_____

VI. Financial Information:

The following worksheet is necessary to determine whether your financial resources will be adequate to cover the monthly living costs at Mary's Meadow. This information will be kept strictly confidential.

Income

Employment income:	$_____	per month
Social Security income:	$_____	per month
SSI income:	$ _____	per month
Employer pension:	$_____	per month
Interest & Dividend income:	$ _____	per month
Annuity income:	$ _____	per month
Support from family:	$ _____	per month
Rental income:	$ _____	per month
Other:	$ _____	per month
Total Monthly Income:	$ _____	per month

Home Equity

If you own your home, please state the approximate amount of equity which would be available if you sold your home. Estimated amount of available home equity: $ _____

Other Assets

Cash on hand: $_____

Money in bank (checking): $_____ Name of Bank:_____

Money in bank (savings):$_____ Name of Bank:_____

Money in bank (other):$_____ Name of Bank:_____

Estimate value of other real estate owned: $ _____

Savings: $_____

Stocks, bonds & other investments: $ _____

Combined Assets (if married): $ _____

Has any money or other items of value been given away, sold, traded, deeded, transferred, or put into a trust during the last 5 years? Yes No

Debts and Obligations (Please specify amount and kind.):

_____

_____

_____

Is there any additional information we should be aware of when reviewing your financial resources? _____

_____

Power of Attorney held by whom? _____

Do you have a living will, advanced directives or healthcare power of attorney or proxy? ** Yes No

**Copies of documents are needed upon residency.

VII. Agreement:

I understand and agree that this application is neither a contract, nor a confirmed reservation for residency. Nothing contained in this document is legally binding on either myself or Mary's Meadow until my application has been reviewed and accepted by Mary's Meadow and a current clinical assessment has been performed. I give permission to Mary's Meadow to conduct a credit check as part of its review of my financial information.

Signature of Applicant: _____

Date of Application: _____

VIII. Questions and Applications:

Questions and/or completed applications for residency should be directed to:

Attn: Laura Harper MSW, LSW

Admissions and Marketing Coordinator
Mary's Meadow at Providence Place
12 Gamelin Street
Holyoke, MA 01040
Phone: (413) 531-0532
Fax: (413) 540-9350