D'YOUVILLE LIFE & WELLNESS COMMUNITY
The Saab Residence
Affordable Assisted Living & Memory Care

Application for Residency

Thank you for your interest in the Saab Residence, a community for those aged 62 or older. Please complete the following application and return to The Saab Residence, Marketing Office, 1085 Varnum Avenue, Lowell, MA 01854. All information will be kept confidential. Upon receipt of your application, a member of our staff will contact you.

PERSONAL INFORMATION

Prospective Resident Name: _____

Social Security Number: _____

Current Address: _____

City/Town: _____ State: _____ Zip: _____

How long have you resided at the address: _____ Years _____ Months

Telephone: _____ Cell/Work Telephone: _____

Applying for: **Assisted Living:** _____ **Memory Care Assisted Living:** _____

Date of Birth: _____ Birth Place: _____ Gender: Male _____ Female _____

Primary Language: _____ Secondary Language: _____

Marital Status: Married _____ Single _____ Widow/er _____ Divorced _____ Separated _____

How many will be residing in the household? _____

Current or Former Occupation: _____

Education: _____ Religious Preference: _____

Did you serve in the military? _____ Branch: _____ Honors: _____

In case of emergency, please notify: (Please provide two)

#1: Name: _____ Relationship: _____

Address _____ City/Town: _____ State: ___ Zip: _____

Telephone: _____ Cell: _____ E-mail: _____

#2: Name: _____ Relationship: _____

Address _____ City/Town: _____ State: ___ Zip: _____

Telephone: _____ Cell: _____ E-mail: _____

Will you bring an automobile to the Saab Residence? _____ Yes _____ No

Automobile information: Make _____ Model _____

License Plate #: _____ Color: _____

How did you hear about the Saab Residence? _____

Reasons for seeking assisted living housing: _____

HEALTH CARE

Physician's name: _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Fax _____

Hospital Affiliation _____ City _____ State _____

_____

Are you currently receiving other medical, nursing or support services? _____ Yes _____ No

Please list agency or person and frequency per week:

	Agency	Frequency
Home Health Services		
Homemaking		
Hospice		
Personal Care Services		
Adult Day Program		
Family		
Other		

Please list your medical diagnosis: _____

_____

Do you need assistance taking your medications? _____

Are you currently taking any medications? If so, please list those medications and frequency: _____

_____

Name of Funeral Home: _____ Address: _____ Phone: _____

MEDICAL INSURANCE INFORMATION

List your medical insurance(s):

Medicare Plan Type _____ Plan # _____

Medicaid Plan Type _____ Plan # _____

Medex Plan Type _____ Plan # _____ Other: _____

Do you have long-term care insurance? _____ Yes _____ No

Company: _____ Policy #: _____

Have you prepared advanced health directives? If so, please provide a copy of each.

Health Care Proxy	☐ Yes	☐ No
Power of Attorney	☐ Yes	☐ No
Guardian	☐ Yes	☐ No
Conservator	☐ Yes	☐ No
DNR/MOLST	☐ Yes	☐ No
Other	☐ Yes	☐ No

HOUSING

With whom do you currently reside?

_____ alone _____ with family _____ assisted living community _____ other

Specify any needs or concerns the staff should be aware of: _____

_____

Describe any special adaptive devices that you may need in your apartment: _____

_____

Do you have any pets? If yes: Type: _____ Weight: _____ lbs.

OTHER

Do you need assistance with any of the following:

Cooking	☐ Yes	☐ No
Housekeeping	☐ Yes	☐ No
Laundry	☐ Yes	☐ No
Understanding fire safety procedures	☐ Yes	☐ No
Financial matters	☐ Yes	☐ No
Shopping	☐ Yes	☐ No
Transportation	☐ Yes	☐ No
Bathing	☐ Yes	☐ No
Dressing	☐ Yes	☐ No
Continence Management	☐ Yes	☐ No
Preparation for bed	☐ Yes	☐ No
Transferring in and out of bed/chair	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Climbing stairs	☐ Yes	☐ No
Taking medication	☐ Yes	☐ No

Other _____

Are you on a special diet? If so, please describe: _____

Can you manage appropriate food selections? _____

Do you have any allergies? (Food, medications, latex, etc.) _____

Do you smoke? _____

Please describe your hobbies, interests, etc. _____

_____

Completing the following section is optional. It would be helpful to us in fulfilling our responsibilities under Fair Housing laws, if you identify your self by one of the following designations:

_____ White _____ African American _____ Asian American _____ Indian _____ Other

Financial Information

Please complete the following information. ***This information will be kept in the strictest confidence.***

MONTHLY INCOME

Social Security (Gross monthly benefit)	$
Pension	$
Other, please list	$
Total monthly income	$

Bank accounts	Average Balance
Bank	$
Bank	$

ADDITIONAL FINANCIAL RESOURCES

Assets	Approximate Capital Value	Monthly Income from Assets
Annuities	$	$
Stocks	$	$
Savings	$	$
Trust Accounts	$	$
CD's	$	$
Bonds	$	$

Residency is contingent upon meeting the income/asset criteria set forth in our residency agreement.

Real estate in applicant's name or joint ownership	Approximate Value
Location	$
Location	$

Any other sources of income? Describe:

Any debts, mortgages, or other financial obligations that would affect your income or assets?

As part of the application process you may be asked to submit the following:

1. Bank statements for the last three months
2. Last year's tax return
3. Current Social Security Award Letter

The financial information included herein is true and submitted in application for residency at The Saab Residence, Affordable Assisted Living & Memory Care. I understand and agree that the foregoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until a Residency Agreement is signed by the parties hereto. I certify that the information which I have provided in this application is true and correct to the best of my knowledge and belief.

Signature of applicant _____ Date _____

D'YOUVILLE LIFE & WELLNESS COMMUNITY
The Saab Residence
Affordable Assisted Living & Memory Care
1085 Varnum Avenue Lowell, Massachusetts 01854 (978) 569-1016 www.dyouville.org