

The Scandinavian Living Center
Application for Residency

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Thank you for your expression of interest in residency at the Scandinavian Living Center, an assisted living facility open to all nationalities. Please print out, complete and mail this form to: **206 Waltham Street, West Newton, MA 02465, Attn: Marketing Director**. Upon receipt of the application, we will contact you to initiate the assessment process to determine the appropriateness of our residence to meet your needs. If you have any questions or require additional information, please don't hesitate to contact the Marketing Director at (617) 527-6566.

I. GENERAL INFORMATION *(Please print legibly)*

1. Applicant Name: _____

2. Street Address: _____

3. City: _____ State _____ Zip Code _____

4. Phone: _____

5. Birth Date: ____ / ____ / ____ Birth Place: _____

6. Social Security #: ____ - ____ - ____

7. Gender: Male Female

8. Marital Status: Married Single Widow/er Divorced Separated

9. Current or former occupation or profession: _____

10. Contact information of person assisting you as you consider an assisted living option *(if applicable)*:

Name: _____

Street Address: _____

City: _____ State _____ Zip Code _____

Phone: _____ Relationship: _____

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II. CURRENT LIVING SITUATION

1. Do you own your own home, or rent? Own Rent
 Other (please explain) _____

2. What type of housing do you live in? Apartment Single-Family
 Multifamily Condo Other _____
3. Do you own an automobile? Yes No
4. Do you drive yourself regularly? Yes No
5. Do you intend to maintain a car? Yes No
6. Do you require someone (friend, relative or other person) to live with you at the present time? Yes No If, yes, name and relationship?:

7. Reason(s) for this need? _____

8. If not, is someone currently visiting you during the day (relative, friend, health care professional)? Yes No
9. Do you smoke? Yes No
10. What are your interests/hobbies? _____

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III. DAILY LIVING

Please use an "X" to describe yourself in the following areas:

<i>TASK</i>	<i>Completely Independent</i>	<i>Some Assistance Appreciated</i>	<i>Comments</i>
Preparing Meals			
Housekeeping			
Laundry			
Bathing			
Fire Safety			
Budgeting			
Shopping			
Transportation			
Dressing			
Walking			

IV. MEDICAL AND INSURANCE INFORMATION

1. Physician's Name: _____
 Address: _____
 Phone: _____

2. Are you on any medications at the present time? Yes No
 If yes, please list the medications that you take (attach separate sheet if necessary): _____

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IV. MEDICAL AND INSURANCE INFORMATION *(continued)*

3. Do you require assistance/reminders to administer your medication(s)?

Yes No

4. Please list all of your medical insurance, including supplemental and long term care:

Insurer: _____ Your ID Number: _____

Insurer: _____ Your ID Number: _____

Insurer: _____ Your ID Number: _____

Your Initials: _____

V. FINANCIAL INFORMATION

1. Long Term Care Insurance

Do you have Long Term Care insurance (yes/no)? If yes, please indicate the following:

Approximate cash value \$ _____

Length of benefit _____

Name of company _____

Policy number _____

2. Assets

Real estate net value (current value less mortgage balance) \$ _____

Savings, CD's and bank accounts \$ _____

Investments \$ _____

Equity from trusts and estates \$ _____

Total Assets \$ _____

3. Liabilities

Loans \$ _____

Other (please note) \$ _____

Total Liabilities \$ _____

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V. FINANCIAL INFORMATION *(continued)*

4. Monthly Income

Employment Income	\$ _____	per month
Social Security Income	\$ _____	per month
Annuity/Pension	\$ _____	per month
Interest and Dividends	\$ _____	per month
Trusts	\$ _____	per month
Life Insurance Benefits	\$ _____	per month
Rental Income	\$ _____	per month
Support from Family	\$ _____	per month
Veteran's Benefits	\$ _____	per month
Total Monthly Income	\$ _____	per month

VI. RESPONSIBILITY FOR PAYMENT

Who will be responsible for payment of applicant's bills? Self ___ Other ___
(If "other," please indicate the following):

Name: _____
Address: _____
Phone Number () _____
Relationship to applicant: _____

VII. AUTHORIZATION FOR FINANCIAL AND CREDIT CHECK:

I hereby authorize the Scandinavian Living Center to request and receive financial, asset, and credit information pertaining to me as may be so required to ascertain my ability to pay for services rendered by the Center should I become a member of the Center's community. I also authorize the release of financial records maintained by other entities, including without limitation financial institutions, to the Center for the purposes stated herein. Other than for reporting to financing sources and government agencies the number of community members and their respective income levels, without identifying names, the Center will hold in confidence, and shall not disclose to any person other than its employees, agents and consultants, any such financial information.

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VII. AUTHORIZATION FOR FINANCIAL AND CREDIT CHECK: *(continued)*

I understand and agree that this application is neither a contract, nor a reservation for residency. Nothing contained in this document is legally binding on either me or the Scandinavian Living Center until a Residency Agreement has been signed by all parties involved.

I certify that the information I have given in this financial information form is true and correct and that any false statement or misrepresentation may result in the cancellation of my application or nullifies my Residency Agreement. I further understand that it is my responsibility to notify the Scandinavian Living Center if my financial situation changes.

By completing and signing this application, I have been made aware of my right to confer with or be accompanied by a Legal Representative, Resident Representative or other advisor.

Signature of Applicant

Date of Application

If application is filled out by someone other than the applicant*:

Signature of person filling out application

Date of Application

Printed name of person filling out application

Relationship to Applicant

**Please provide copy of Power of Attorney, if applicable.*