Name: First MI Last: _____

Address1: _____

Address2: _____

City State Zip: _____

Email: _____

Case Manager Email: _____

THIS SECTION FOR APPLICANT:

Date Generated:

Applicant: Mail application to the address at left.

Fold on this line

THIS SECTION FOR WAITLIST ADMINISTRATOR:

Landlords: IF REJECTING THIS APPLICATION, please email, mail, or fax the form below to HousingWorks. We will pass it on to the applicant. Include this page so we know who the application is for!

We will also update our system, so the changed status of your waitlists will reach many thousands of applicants and their housing advocates. Also, you will boost your Fair Housing and ADA compliance exponentially!

For Landlords Only!
support@housingworks.net
HousingWorks
P.O. Box 231104
Boston, MA 02123
617-536-8561 fax

- ○ **This waitlist is closed. The only waitlists open at present are:**

  _____

  _____

- ○ **This is not the right application. We have enclosed the correct application.**
- ○ **You do not appear to qualify for this property, because:** _____

Name of Waitlist Administrator *optional* _____

Phone of Waitlist Administrator *optional*: _____ - _____ - _____ X _____

Date Time Received. Application will be stamped to show when it was received:

Erase ENTIRE FORM

DO NOT LEAVE ANY QUESTION UNANSWERED!

HEAD OF HOUSEHOLD'S FIRST NAME _____

HEAD OF HOUSEHOLD'S COMPLETE MIDDLE NAME _____

HEAD OF HOUSEHOLD'S LAST NAME (EX: BAEZ GONZALEZ) _____ SUFFIX _____

YOUR MOTHER'S LAST NAME WHEN SHE WAS A CHILD _____

ANSWER THIS: Yes No Does the HoH have a Social Security Number? ***If "Yes" you must provide the full SSN!***

HEAD OF HOUSEHOLD'S SOCIAL SECURITY NUMBER (###-##-####) _____

HEAD OF HOUSEHOLD's DATE OF BIRTH mm/dd/yyyy _____

GENDER M, F, T, etc. **F**

ETHNICITY: Hispanic/Latino, Non-Hispanic/Non-Latino, **Client Refused**

RACE: Asian , Black or African American, White, American Indian or Alaskan Native, Pacific Islander or Native Hawaiian, Other or Multi-Racial, **Client Refused**

_____ _____

I am not claiming any R.A. or Special Circumstances at the moment (else fill in any of the items below)

- **Fully Accessible Wheelchair** Unit
- **No-Steps unit** (elevator to any floor)
- **First-Floor unit only**
- **Vision-Impaired** Unit
- **Hearing-Impaired** Unit
- Unit for **Environmental Allergies**
- Need an **Interpreter - Explain:** _____
- **Domestic Violence Victim**
- **Personal Care Attendant**

HoH's CAREER STAGE
Employed Unemployed Retired FT Student PT Student

ANY VETERANS in HH? Yes No

PERMANENT MOBILE RENTAL ASSISTANCE, if any
I do not have mobile rental assistance Mobile Section 8 voucher MRVP AHVP VASH or similar

CRIMINAL RECORD AND SEX OFFENDER

Head of Household: Any **Felony/Conviction?** Yes No Any **Misdemeanor Conviction?** Yes No

Other Members: Any **Felony Convictions?** Yes No Any **Misdemeanor Conviction?** Yes No

Is **anyone** in HH subject to a **lifetime sex offender registration** in any state? Yes No Details

ANY PETS? Yes No Number of Pets: _____ Describe: _____

HOUSEHOLD SIZE AND COMPOSITION

_____ ← **# Adults** _____ ← **# Children** **0** ←**Total** # in Household

ANNUAL INCOME _____

DOCUMENTED DISABILITY? Yes No

CURRENT HOUSING STATUS Homeless Housing Loss in 14 days Homeless under other federal status
Homeless because Fleeing domestic violence At risk of homelessness Stably Housed

BEST TELEPHONE NUMBER TO USE _____ SECOND TELEPHONE _____

EMAIL ADDRESS _____

WHERE YOU LIVE OR BACKUP ADDRESS ☐ check this box if backup address is the same as best mailing address below.

AddressLine 1 _____ Apt # or "care of" name _____

City _____ State _____ Zip _____

BEST MAILING ADDRESS

Address Line 1 _____ Apt # or "care of" name _____

City _____ State _____ Zip _____

PREFERRED # OF BEDROOMS? _____

SPECIAL CIRCUMSTANCES? (*some programs may grant you a priority status)*

Disability Elder Local Resident Local Employee Local Student Homeless Vet. Fleeing Dom. Viol.
Rent-burdened 40% Rent-burdened 50% HUD VAWA Certification Victim of Hate Crime.
Displaced by: Urban Renewal Sanitary Code Natural Forces Other _____

MOUNT PLEASANT HOME

301 SOUTH HUNTINGTON AVENUE, JAMAICA PLAIN, MA 02130
PHONE: 617.522.7600 ~ FAX: 617.522.0201

INFO@MOUNTPLEASANTHOME.ORG ~ WWW.MOUNTPLEASANTHOME.ORG

APPLICATION FOR RESIDENT ADMISSION

Mount Pleasant Home is licensed by the Massachusetts Department of Public Health as a Level IV long-term care facility (rest home) and provides housing, meals, support services, and medical oversight in a residential setting where residents do not require skilled nursing care on a routine basis. The Home administers medications, schedules medical appointments, serves three meals daily, and features 24-hour staff to respond to residents who are not capable of living on their own. Mount Pleasant Home is a non-smoking facility; no smoking is allowed in the building.

Qualifications for residency at Mount Pleasant Home include the following:

- Age 62 years or older
- Income Eligible
- Medical appropriateness based on DPH license requirements for Level IV residential care facility and physician's assessment.

PLEASE PRINT CLEARLY - FILL IN ALL ITEMS THAT APPLY

VITAL INFORMATION

Date of Application: _____

How did you hear about Mount Pleasant Home? **via the www.housingworks.net website**

Applicant's Full Name: _____

Sex (M/F): F Date of Birth: _____ Social Security Number: _____

Father's Full Name: _____
***Full names** are necessary for some public assistance programs.*

Mother's Full Name: _____
***Full names** are necessary for some public assistance programs.*

Applicant's Home Address: _____

City: _____ State: _____ Zip: _____

How long at home address? _____

Mailing Address if different: _____

Primary Phone: _____Other Phone: _____

Email: _____

Temporary location if not currently at Home Address: _____

Birth Place: _____ Birth Name (if different): _____

If Veteran, list Service Branch: _____Dates: _____

U.S. Citizen? ❑ Yes ☒ No - Alien Registration #: _____

Can you provide documentation to verify your alien status? ❑ Yes ☒ No

Primary Language: ❑ English ❑ Spanish ☒ Other languages spoken _____

Current Marital Status:

❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

****

Name of person preparing application, if not applicant: _____

Relationship to Applicant: _____

Emergency Contact for applicant? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Other Phone: _____ Fax: _____

Email: _____

LEGAL INFORMATION

If applicable, please check appropriate legal relationship, complete contact information below, and attach copy of the particular legal document establishing such a relationship.

❑ **Power of Attorney** ❑ **Conservator** ❑ **Guardian** ❑ **Rogers Guardian**

Effective date: _____

Name: _____ Relationship: _____

Emergency Contact for applicant? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Other Phone: _____ Fax: _____

Email: _____

****

❑ **Healthcare Proxy** Effective date: _____ **(*Required for admission*)**

Name: _____ Relationship: _____

Emergency Contact for applicant? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Other Phone: _____ Fax: _____

Email: _____

****

Advanced Directives

Do you have a Do Not Resuscitate (DNR) Order in effect? ❑ Yes ❑ No

APPLICANT'S CHILDREN (IF APPLICABLE)

Number of Applicant's Children: _____

Name: _____ Relationship: _____

Emergency Contact for applicant? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Other Phone: _____ Fax: _____

Email: _____

****

Name: _____ Relationship: _____

Emergency Contact for applicant? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Other Phone: _____ Fax: _____

Email: _____

****

Name: _____ Relationship: _____

Emergency Contact for applicant? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Other Phone: _____ Fax: _____

Email: _____

Please attach a separate piece of paper if more room is needed.

OTHER RELATIVES OR INTERESTED FRIENDS

Name: _____ Relationship: _____

Emergency Contact for applicant? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Other Phone: _____ Fax: _____

Email: _____

****

Name: _____ Relationship: _____

Emergency Contact for applicant? ❑ Yes ❑ No

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____Other Phone: _____ Fax: _____

Email: _____

Please attach a separate piece of paper if more room is needed.

BACKGROUND INFORMATION

Highest Level of Education completed: _____

Occupations: _____

Date Last Employed: _____

Organizational Memberships: _____

Interests and Hobbies: _____

Religious Affiliation/Preference: _____

Contact Person and Phone: _____

Funeral and Burial Arrangements:

Funeral Home/Director: _____

❑ Prepaid Funeral Plan

❑ Burial Insurance – Company/Policy #: _____

Cemetery: _____

Deed held by: _____

MEDICAL INFORMATION

Physicians

Primary Care Physician Name: _____

Address: _____ Hospital/Clinic: _____

Office Phone: _____ Office Fax: _____

****

Specialty Care Physician Name: _____ Specialty: _____

Address: _____ Hospital/Clinic: _____

Office Phone: _____ Office Fax: _____

****

Specialty Care Physician Name: _____ Specialty: _____

Address: _____ Hospital/Clinic: _____

Office Phone: _____ Office Fax: _____

****

Specialty Care Physician Name: _____ Specialty: _____

Address: _____ Hospital/Clinic: _____

Office Phone: _____ Office Fax: _____

Please attach a separate piece of paper if more room is needed.

Hospital and Insurance Information

❑ Medicare Part A (Hospital Insurance) ❑ Yes ❑ No ID #: _____

❑ Medicare Part B (Medical Insurance) ❑ Yes ❑ No

Is your Medicare Part B premium deducted from your Social Security payment? ❑ Yes ❑ No

❑ Medicare Part D (Prescription Drug Plan) ❑ Yes ❑ No

Insurance Company: _____ ID #: _____

Is your Medicare Part D premium deducted from your Social Security payment? ❑ Yes ❑ No

❑ Mass Health (Medicaid) ❑ Yes ❑ No ID #: _____

Other Medical Insurance ❑ Yes ❑ No Name:_____ ID #: _____

Care History and Status

Date of last Primary Care Physician exam: _____

Hospitalization(s) within the last ten years: _____

_____

_____

Have you ever been a resident of a retirement or nursing home? ❑ Yes ❑ No

If yes, provide details below, including name and location of facility, and dates of stay:

_____

_____

PERSONAL CARE ASSESSMENT

Ambulation or Transfer

Are you able to walk independently? ❑ Yes ❑ No

Do you use a:

- ❑ Cane
- ❑ Walker
- ❑ Wheelchair

Are you able to independently transfer from your wheelchair to a chair or bed? ❑ Yes ❑ No

Have you fallen in the past 6 months? ❑ Yes ____ # times ❑ No

Do you have a handicap or disability that requires you to occupy a wheelchair-adapted unit? (Entry is by means of an accessible path; doors have levered handles. Bath includes special grab bars, a hand held shower, and mirrors set at a lower level. Halls and doorways are extra wide.) ❑ Yes ❑ No

Showering and Bathing

Do you prefer: ❑ Tub ❑ Shower

Do you need:

❑ Only assistance getting in and out of shower or tub

❑ Supervision when in shower or tub

❑ Total assistance when bathing

❑ A shower chair for bathing

How often do you bathe currently? _____

Do you need reminders to bathe? ❑ Yes ❑ No

Continence

Are you incontinent? ❑ Totally ❑ Frequently ❑ Occasionally ❑ Never

❑ Urine ❑ Bowel Movement

Do you wear incontinence products? ❑ Yes ❑ No

❑ Occasionally ❑ Consistently

Do you have a prescription from your doctor for incontinence products? _____

When does the prescription expire? _____

What pharmacy/company do you receive incontinence products from? _____

Do you use a ❑ Bedside Commode ❑ Elevated Toilet Seat ❑ Urinal?

Do you have a ❑ Catheter ❑ Stoma ❑ Colostomy?

Are you able to manage it independently? ❑ Yes ❑ No

Dressing

❑ I am able to dress independently

❑ I am able to choose clothes appropriate to weather and situation

❑ I need daily assistance dressing – Please explain: _____

_____

❑ I need occasional assistance dressing – Please explain: _____

_____

❑ I need reminders to change my clothes

Eating

❑ I can feed myself independently

❑ I require assistance – Please explain: _____

_____

I require the following diet:

❑ Diabetic ❑ Low fat ❑ Low salt ❑ Pureed ❑ Vegetarian ❑ No special diet

Sleeping

I usually get up at: _____

❑ I wake up independently

❑ I require someone to wake me

I usually go to bed at: _____

Consistent sleep disturbances? ❑ Yes ❑ No Please explain: _____

_____

Assistive Equipment

Do you have any of the following?

❑ Hearing aids

❑ Dentures

❑ CPAP machine

Diabetes (If you are diabetic, please answer the following questions)

Do you check your blood sugar independently with your glucometer? ❑ Yes ❑ No

Do you require insulin injections? ❑ Yes ❑ No

Are you able to inject and measure insulin yourself? ❑ Yes ❑ No

If no, who currently injects and measures your insulin? _____

Visiting Nurse Services (VNA) or Home Health Aide Services (HHA)

Do you currently receive VNA or HHA services? ❑ Yes ❑ No

Which VNA/HHA company? _____

What services do they provide you? _____

Smoking

Do you currently smoke cigarettes, pipes, or cigars? ❑ Yes ❑ No

If yes, how many cigarettes or times a day do you smoke? _____

Do you understand that Mount Pleasant Home is a non-smoking facility and that smoking is allowed outside only? ❑ Yes ❑ No

Total Daily Personal Care Assistance

How many minutes per day do you expect to need for personal care assistance? _____

Please explain:

_____

FINANCIAL INFORMATION

Assets and Income

Please provide the following information regarding ALL sources of assets and income. On this page, list all **ASSETS** (bank accounts, investments, real estate, and life insurance with cash value, etc.). An accurate list of assets is required to enable Mount Pleasant Home to plan your residency and to assist in your enrollment in public pay subsidy programs, if needed.

On the next page, list each source of **INCOME** (Social Security, SSI, pension, Veterans' benefits, interest and dividends, and trust and other income). Please list ***gross*** income amounts (before deductions have been taken out, for example, for health insurance or taxes). Mount Pleasant Home reserves the right to request income tax returns for the three (3) most recent years to confirm income and determine eligibility for public payment subsidies.

ASSETS

BANK ACCOUNTS (INCLUDE JOINTLY OWNED ACCOUNTS ALSO)					
Owned Jointly	**Account Type (Checking/Savings/ CD)**	**Bank Name**	**Account Number (If known)**	**Current Balance**	**Interest Rate**
❑ Yes ❑ No				$	%
❑ Yes ❑ No				$	%
❑ Yes ❑ No				$	%
❑ Yes ❑ No				$	%
❑ Yes ❑ No				$	%
			Total Value of all Bank Accounts	**$**	

OTHER ASSETS (INCLUDE JOINTLY OWNED ACCOUNTS ALSO)				
Owned Jointly	**Asset Type**	**Current Value**	**Annual Dividends/ Interest or Other Income From Asset**	**Details for Distribution**
❑ Yes ❑ No	Mutual Funds	$	$	
❑ Yes ❑ No	Stocks or Bonds	$	$	
❑ Yes ❑ No	Cash	$	$	
❑ Yes ❑ No	Home and other Real Estate	$	$	
❑ Yes ❑ No	Motor Vehicle	$	$	
❑ Yes ❑ No	Other Assets	$	$	
Total of all Other Assets		**$**	**$**	

Have you given away property or other assets in the past three years? ❑ Yes ❑ No

Have you sold property or other assets in the past three years? ❑ Yes ❑ No

If yes, what is the current market value of the asset(s)? $_____

Do you currently have life insurance with cash value? ❑ Yes ❑ No

If yes, what is the current cash surrender value? $_____

Life insurance company name: _____

HOUSEHOLD INCOME

Owned Jointly	**Source of Income**	**Gross Monthly Income**	**Annual Gross Amount**	**Deductions & Withholding from Monthly Check (i.e., tax, insurance, union dues, etc.)**
	Social Security Retirement	$	$	$ Reason:
	Social Security Disability	$	$	$ Reason:
	SSI	$	$	$ Reason:
❑ Yes ❑ No	Pension Name:	$	$	$ Reason:
❑ Yes ❑ No	Annuity/Trust*	$	$	$ Reason:
❑ Yes ❑ No	Other:	$	$	$ Reason:
❑ Yes ❑ No	Interest and Dividends	$	$	$
Total Household Income		**$**	**$**	

* Trust officer's Name (if applicable): _____

Address: _____

Phone: _____ Email: _____

LIABILITIES

Indebted Jointly	Liability Type (credit card, mortgage, personal loans, car loan, etc.)	Current Balance	Payment Amount and Frequency	Interest Rate	Plan for Payoff
❑ Yes ❑ No		$	$ per		
❑ Yes ❑ No		$	$ per		
❑ Yes ❑ No		$	$ per		
❑ Yes ❑ No		$	$ per		
	Total Liabilities	$			

ONGOING MONTHLY RESPONSIBILITIES AND DETAILS:

❑ Alimony $ _____

❑ Child Support $ _____

❑ Cell Phone $_____

❑ Car Insurance $ _____

❑ Other $_____

❑ Other $_____

❑ Other $_____

FAIR HOUSING INFORMATION

CURRENT HOUSING SITUATION

Are you being displaced from your current housing? ❑ Yes ❑ No

If yes, please explain the circumstances: _____

_____

Are you without or about to be without housing? ❑ Yes ❑ No

If yes, please explain the circumstances: _____

Are you now living in government subsidized housing? (Section 8, section 236, Public Housing) ❑ Yes ❑ No

If yes, please list facility name and contact information: _____

_____

Due to the referral basis of applications as determined by health needs, applicants will be offered the first available room for which they meet the criteria. If there are no available rooms, eligible applicants will be placed on a waiting list in the order that their completed application was received. The waiting list is based into four categories:

1. Meets guidelines for Market Rate
2. Meets guidelines for Barrier Free, Handicap Preference
3. Meets guidelines for income below 30% of AMI (Area Median Income)
4. Meets guidelines for Homeless Preference

RESIDENT RELOCATIONS
For those individuals requiring a barrier-free room, verification will be required by an appropriate professional, when the reasonable accommodation request is submitted. Residents who occupy, but do not require the features of an accessible room, must agree to transfer to another room in the building if another resident or applicant requires an accessible room and none is available.

FAIR HOUSING POLICY
Mount Pleasant Home offers all units on an open occupancy basis. Mount Pleasant Home does not discriminate on the basis of race, color, national origin, sex, age, religion, handicap, familial status, children, ancestry, marital status, sexual orientation or preference, or veteran history.

TDD RELAY
TDD relay service is available to all applicants and residents through the use of a TDD relay operator. For TDD assistance, please call 800-439-2370.

504 COORDINATOR
Mount Pleasant Home's 504 Coordinator may be reached by calling 617-522-7600 and asking for Kathy Seaman. You may also write to the 504 Coordinator by addressing a letter to: Kathy Seaman, Mount Pleasant Home, 301 South Huntington Avenue, Jamaica Plain, MA 02130.

REASONABLE ACCOMMODATIONS
Mount Pleasant Home is committed to offering reasonable accommodations to applicants and residents who have physical, developmental, or mental limitations or challenges. Requests for units adapted for the physically challenged, or other accommodations in policy or procedures, require confirmation of the limitation which will be accommodated by the change. A description of the "qualifying handicap" may need to be provided by the applicant's physician or service provider to confirm the reasonable accommodation.

Reasonable accommodations are also limited by the financial ability of the development to make any needed changes. Changes in policy, procedures, and design may be governed by the following considerations:

1. The requested accommodation will not result in an undue administrative burden,

2. The requested accommodation will not result in an undue financial burden, and/or
3. The requested accommodation will not result in a fundamental alteration in the nature of the housing program offered to all residents.

PREFERENCE CATEGORIES

A preference for seven (7) rooms will be occupied by previously homeless individuals. A preference for three (3) barrier free rooms will be occupied by individuals with a medically verified need for a special adapted room. Other preference categories do not apply as this is residential care licensed by the Department of Public Heath and residents are placed based on evaluation and referrals from qualified staff at area hospitals and elderly resource/care facilities according to guidelines recognized by the Department of Public Heath and physician's orders.

MINIMUM SUITABILITY STANDARDS

Selected applicants must also meet Minimum Suitability Standards. The following circumstances would disqualify an applicant household for housing:

1. The applicant has failed to provide information reasonably necessary for the housing provider to process the applicant's application.
2. The applicant has misrepresented or falsified any information required to be submitted as part of the applicant's application (determined upon verification of information).
3. The applicant requires care or services that cannot be provided. Additional application, medical information and personal interview required.

RACE/NATIONAL ORIGIN

The Federal Government asks that we obtain the following information in order to monitor the owner's compliance with Equal Housing Opportunity and Fair Housing laws. The law provides that an applicant may not be discriminated against on the basis of the information supplied below or whether or not the information is furnished. Completing this section is voluntary.

_____ White/Non-Minority
_____ African American
_____ American Indian/Native American
_____ Asian
_____ Hispanic
_____ Other_____
_____ I do not wish to furnish the above information

CONFLICT OF INTEREST POLICY

No owner, developer or sponsor of a project assisted with HOME funds (or officer, employee, agent, elected official of appointed officials or consultant of the owner, developer or sponsor) whether private, for profit or non-profit (including a community housing development organization (CHDO) when acting as an owner, developer or sponsor) may occupy a HOME-assisted affordable housing unit in a project. This provision also applies to *immediate* family members of an officer, employee, agent, elected official of appointed officials or consultant of the owner, developer or sponsor. This provision does not apply to an individual who

receives HOME funds to acquire or rehabilitate his or her principal residence or to an employee or agent of the owner or developer of a rental housing project who occupies a housing unit as the project manager or maintenance Worker.

Any request for a waiver of this policy by the owner or developer must be **approved** by HUD as described in 24 CFR Part 92.356 **prior to** the applicant household being approved by Management for occupancy. If the owner or developer does not seek a waiver or a waiver from HUD is not obtained, the household will be rejected for failure to meet the applicable programmatic eligibility criteria. All requests for waivers processed by the owner's agent shall be done in a consistent manner and in accordance with our commitment to and compliance with applicable fair housing laws.

If you are requesting a waiver of this policy or you became aware of a conflict under the terms of this policy, please notify Kathy Seaman, Director of Admissions at Mount Pleasant Home at 617-522-7600.

This housing is available on an equal opportunity basis. If you feel that you have been discriminated against in the application process, you may contact:

Boston Fair Housing Commission, City Hall, Room 966, 1 City Hall Square, Boston, MA 02201
Phone: (617) 635-4408;
or the Mass Commission Against Discrimination, phone: (617) 727-3990;
or the US Dept of Housing and Urban Development, phone: (617) 994-8300.

AFFIRMATION

PLEASE READ EACH ITEM BELOW CAREFULLY BEFORE YOU SIGN

1. I hereby certify that I have reviewed the material in this application and the information provided in this application is correct to the best of my knowledge.

2. I understand that this is a preliminary application and the information provided does not guarantee housing. Additional information will be necessary to complete the application process.

3. I hereby give Mount Pleasant Home authorization to verify the information in this application.

4. **WARNING:** Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the US as to any matter within its jurisdiction. It is a criminal offense to make willfully false statements or misrepresentations on this preliminary application.

APPLICANT'S SIGNATURE:_____DATE:_____
(Please note: Applicant MUST sign even if there is a Power of Attorney appointed.)

GUARDIAN'S SIGNATURE:_____DATE:_____
(if applicable)

Mount Pleasant Home

SEND THIS APPLICATION TO:

Mount Pleasant Home
ADMISSIONS
301 S. Huntington Ave.
Jamaica Plain, MA 02130

Info@MountPleasantHome.org

Phone: 617-522-7600
Fax: 617-522-0201

We thank you and will contact you shortly!

MOUNT PLEASANT HOME

301 SOUTH HUNTINGTON AVENUE, JAMAICA PLAIN, MA 02130
PHONE: 617.522.7600 ~ FAX: 617-522-0201

INFO@MOUNTPLEASANTHOME.ORG ~ WWW.MOUNTPLEASANTHOME.ORG

Medical Records Release

Applicant:
Fill out the following information to allow Mount Pleasant Home to contact your health care providers to obtain your medical records.

Doctor's Name: _____

Hospital/Facility: _____

Address: _____

Phone: _____

Fax: _____

To Whom It May Concern:
I hereby authorize the release of any or all of my medical records to:

Mount Pleasant Home
301 S. Huntington Ave.
Jamaica Plain, MA 02130

617-522-7600
Fax: 617-522-0201

Print Name: _____

Signature: _____

*** FAX, MAIL or DELIVER the following pages to your Primary Care Physician** *

MOUNT PLEASANT HOME

301 SOUTH HUNTINGTON AVENUE, JAMAICA PLAIN, MA 02130
PHONE: 617.522.7600 ~ FAX: 617-522-0201

INFO@MOUNTPLEASANTHOME.ORG ~ WWW.MOUNTPLEASANTHOME.ORG

PHYSICIAN'S STATEMENT FOR RESIDENT ADMISSION

Mount Pleasant Home is licensed by the Massachusetts Department of Public Health as a Level IV long-term care facility (rest home) and provides housing, meals, support services, and medical oversight in a residential setting where residents do not require skilled nursing care on a routine basis. The Home administers medications, schedules medical appointments, serves three meals daily, and features 24-hour staff to respond to residents who are not capable of living on their own. Mount Pleasant Home is a non-smoking facility; no smoking is allowed in the building.

Qualifications for residency at Mount Pleasant Home include the following:

- Age 62 years or older
- Income Eligible
- Medical appropriateness based on DPH license requirements for Level IV residential care facility and physician's assessment.

APPLICANT:
Bring this form to your physician or ask Mount Pleasant to fax it to your provider.

PHYSICIAN:

The Department of Public Health requires that each resident have a Primary Care Physician and that we maintain a record of the health of a resident prior to moving and while living at MPH. The following information will be used to help us determine whether Mount Pleasant Home will be a good match for your patient. Thank you for your assistance.

*****PLEASE ATTACH MEDICAL RECORD OR RESULTS OF LAST PHYSICAL*****

Please fill out the following information:

Patient Name: _____ Sex (M/F): _____ DOB: _____

Home Address: _____

Date of most recent physical examination: _____

Allergies: _____

Diagnosis (ACTIVE medical problems):

_____

_____

Pertinent INACTIVE medical problems, medical history:

_____

_____

Emotional/psychological history pertinent to patient's living setting:

_____

_____

Treatments (specific orders and frequency); special needs:

_____

_____

Special equipment or therapy (PT, OT, speech – please indicate if resident is currently receiving and should continue): _____

Has applicant ever been treated for a nervous or mental disorder? ❑ Yes ❑ No

If yes, where and when? _____

_____

Is resident oriented to time, place and person? ❑ Yes ❑ No

If no, please explain: _____

_____

Diet and Restrictions: _____

Physical Exam Data:

Weight_____Height _____

Blood Pressure _____S/A _____

Temperature _____Mantoux _____

Chest X-Ray _____Other _____

Start Date	Medication Dose and Schedule Please include appropriate time of day for each med.	Notes

Medical History

(Please check all that apply)

Heart		Neurological		Other	
Arteriosclerotic heart disease	_____	Alzheimer's	_____	Anemia	_____
Cardiac dysrythmias	_____	Dementia	_____	Arthritis	_____
Heart failure	_____	Aphasia	_____	Cancer	_____
Hypertension	_____	Memory deficit	_____	Osteoporosis	_____
Hypotension/Syncope	_____	Multiple Schlerosis	_____	Seizure disorder	_____
Peripheral vascular disease	_____	Parkinson's	_____	Thyroid disorder	_____
Other cardiovascular disease	_____			UTI	_____
Pacemaker	_____			_____	
				_____	

Pulmonary		Sensory		Psychiatric	
Emphysema	_____	Cataracts	_____	Anxiety disorder	_____
Asthma	_____	Glaucoma	_____	Depression	_____
COPD	_____	Macular Degener.	_____	Manic depressive	_____
Pneumonia	_____	Neuropathy	_____	Panic disorder	_____
Pneumocystosis	_____	Deafness	_____	Schizophrenia	_____
				Paranoia	_____
				Paranoid Schizo.	_____

Please check the appropriate status for each of the following:

1. Medication Administration

____Complete self-management and self-administration of all medications
____Needs only supervision and some assistance to self-administer
____Needs only supervision to self-administer
____Needs administration by licensed personnel

2. Ambulation or Transfer

____Fully independent
____Needs supervision
____Needs assistance

3. Eating

____Fully independent
____Needs supervision
____Needs assistance

4. Bathing

____Fully independent
____Needs supervision
____Needs assistance

5. Toileting

____Fully independent
____Needs supervision
____Needs assistance
____Incontinent
___ BM ___ Urine

6. Dressing

____Fully independent
____Needs supervision
____Needs assistance

7. Grooming/Personal Hygiene

____Fully independent
____Needs supervision
____Needs assistance

8. Nutrition Management & Compliance

____Fully independent
____Needs supervision
____Needs assistance

9. Smoking Management

No smoking is allowed within the building at Mount Pleasant Home.

____Not Applicable
____Fully independent
____Needs supervision
____Needs assistance

This applicant is medically and socially appropriate for Level IV care and I approve of

_____ _____'s residency at Mount Pleasant Home.

Physician Signature:_____ Date: _____

Physician Name: _____Email: _____

Hospital/Clinic: _____

Address: _____

Phone: _____

Physician:

PLEASE **FAX** THIS FORM
AND
MEDICAL RECORD
to
Mount Pleasant Home
at
617-522-0201

Or **MAIL** to:

Mount Pleasant Home
Admissions Department
301 South Huntington Avenue
Jamaica Plain, MA 02130

If you have any questions, please call our Admissions Department at 617-522-7600

Thank you!

IF TYPING YOUR ANSWERS, CLICK THIS BUTTON TO SEE IF YOU SKIPPED ANYTHING