

MOUNT PLEASANT HOME



APPLICATION FOR ADMISSION

PART 1 OF 2 - FINANCIAL APPLICATION

Mount Pleasant Home is licensed by the Massachusetts Department of Public Health as a long-term care facility and provides housing, meals, support services, and medical oversight in a residential setting. 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, and assistance in certain areas. Residents do not require skilled nursing care on a routine basis. Mount Pleasant Home is a non-smoking facility; no smoking is allowed in the building.

The purpose of this application is to determine whether the applicant is categorically eligible for housing at Mount Pleasant Home and if so would qualify for the **MEDICAL AND SOCIAL APPLICATION**.

Qualifications for housing include the following:

- Persons 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

DATE: _____

Applicant's Full Name: _____

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

Present Address: _____

Street and Address

Home Phone: _____ Work Phone: _____

City State Zip Code

Present location if not currently at Present Address: _____

Person preparing application, if different: _____

Relationship to Applicant: _____

Phone: _____ Email: _____

Other Contact Information: _____



PART A: ASSETS and INCOME

Please provide the following information regarding ALL sources of assets and income. List all checking and savings accounts, real estate, IRAs, Keoughs, and certificates of deposit. In the second table, please include salary, social security, pension, SSI, veterans' benefits, interest, dividends, trust income, rent from other properties, allowances from family, and any other income. Please give 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.

BANK ACCOUNTS: (INCLUDE JOINTLY OWNED ACCOUNTS)

Owned Jointly	Account Type (Checking, Savings, etc.)	Bank Name	Account Number (If known)	Current Balance	Interest Rate
<input type="checkbox"/> No <input type="checkbox"/> Yes				\$	%
<input type="checkbox"/> No <input type="checkbox"/> Yes				\$	%
<input type="checkbox"/> No <input type="checkbox"/> Yes				\$	%
<input type="checkbox"/> No <input type="checkbox"/> Yes				\$	%
<input type="checkbox"/> No <input type="checkbox"/> Yes				\$	%
TOTAL VALUE OF ALL BANK ACCOUNTS				\$	

OTHER ASSETS: (INCLUDE JOINTLY OWNED ACCOUNTS)

Owned Jointly	Asset Type	Current Value	Annual Dividends/ Interest or Other Income From Asset	Details for Distribution
<input type="checkbox"/> No <input type="checkbox"/> Yes	Mutual Fund	\$	\$	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Stocks or Bonds	\$	\$	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Cash	\$	\$	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Paid-up Life Insurance	\$	\$	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Home and other Real Estate	\$	\$	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Motor Vehicle	\$	\$	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Other Assets	\$	\$	
		Total \$	Total \$	
TOTAL VALUE OF ALL ACCOUNTS				\$

1. Have you given away or sold any property or other assets in the past three years? No Yes
 If yes, what is the current market value of the asset(s)? \$ _____



HOUSEHOLD INCOME (Social Security, SSI, SSDI, Pension, Annuity, other):

Owned Jointly	Social Security Number	Source of Income	Gross Monthly Income	Annual Gross Amount
<input type="checkbox"/> No <input type="checkbox"/> Yes		Social Security	\$	\$
<input type="checkbox"/> No <input type="checkbox"/> Yes		Pension Name:	\$	\$
<input type="checkbox"/> No <input type="checkbox"/> Yes		Pension Name:	\$	\$
<input type="checkbox"/> No <input type="checkbox"/> Yes		SSI/SSDI	\$	\$
<input type="checkbox"/> No <input type="checkbox"/> Yes		Annuity	\$	\$
<input type="checkbox"/> No <input type="checkbox"/> Yes		Interest & Dividends (from Part A)	\$	\$
<input type="checkbox"/> No <input type="checkbox"/> Yes		Other _____ _____	\$	\$
			Bank Accounts	\$
			Total Other Assets	\$
			Total Income	\$

PART B: LIABILITIES

Indebted Jointly	Liability Type (credit card, mortgage, personal loans, car loan, etc.)	Current Balance	Payment Amount and Frequency	Interest Rate	Plan for Payoff
<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	\$ per		
<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	\$ per		
<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	\$ per		
<input type="checkbox"/> No <input type="checkbox"/> Yes		\$	\$ per		
Total Liabilities		\$			

PART C: HOSPITAL & MEDICAL INSURANCE

- Medicare Part A (Hospital Insurance) No Yes ID #: _____
 Medicare Part B (Medical Insurance) No Yes
 Medicare Part D (Prescription Drug Plan) No Yes ID #: _____
 Mass Health (Medicaid) No Yes ID #: _____
 Other Medical Insurance No Yes Name: _____ ID #: _____



Do you have any medical expenses not covered by insurance? _____

If yes, describe briefly: _____

PART D: NEED FOR SPECIALLY ADAPTED UNIT

Mount Pleasant Home has available three (3) units specially adapted for wheelchair use. The entry is by means of an accessible path; the doors have levered handles. The bath includes special grab bars, a hand held shower, and mirrors set at a lower level. The halls and doorways are extra wide.

Do you have a handicap or disability which requires that you occupy the above described wheelchair adapted unit? No Yes

PART E: CURRENT HOUSING CONDITION

1. Are you being displaced from your current housing? No Yes
If yes, please explain the circumstances:

2. Are you without or about to be without housing? No Yes
If yes, please explain the circumstances:

3. Are you now living in government subsidized housing? (For example, section 8, section 236, Public Housing)
 No Yes
If yes, please list facility name and contact information:

PART F: OTHER INFORMATION

1. Do you have a Primary Care Physician? No Yes

PCP's Name: _____ Phone: _____

Address: _____

2. How did you hear about this facility? _____



3. Are you a United States Citizen? No Yes
Or, do you have legal alien status which you can verify? No Yes

Please be advised that all applicants may be verified through the governmental SAVE (Systematic Alien Verification for Entitlements) Verification Program. The SAVE Program is a nationally database used to obtain the legal immigration status to determine a non-citizen's applicant's eligibility for public benefits.

4. Please list the names, addresses, and phone numbers of two relatives or friends who know how to contact you, and who could be contacted if we cannot reach you, or in an emergency.

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Relationship to you: _____ Relationship to you: _____

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 lists will be based into four categories.

- Meets guidelines for Market Rate
- Meets guidelines for Barrier Free, Handicap Preference
- Meets guidelines for income below 30% of AMI (Area Median Income)
- 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 NYNEX TDD relay operator. For TDD assistance, please call 1-(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, Director of Development and Outreach, Mount Pleasant Home, 301 South Huntington Avenue, Jamaica Plain, MA 02130
Phone: (617) 522-7600



REASONABLE ACCOMODATIONS

Mount Pleasant Home is committed to offering reasonable accommodations to applicants, 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 Health 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 Health 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



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.

PART G: PLEASE READ EACH ITEM BELOW CAREFULLY BEFORE YOU SIGN

AFFIRMATION

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.

APPLICANTS SIGNATURE: _____ DATE: _____

SECOND APPLICANT'S SIGNATURE: _____ DATE: _____



MOUNT PLEASANT HOME



APPLICATION FOR ADMISSION

PART 2 OF 2 – MEDICAL AND SOCIAL APPLICATION

Mount Pleasant Home is licensed by the Massachusetts Department of Public Health as a long-term care facility and provides housing, meals, support services, and medical oversight in a residential setting. The Home administers medications, schedules medical appointments, serves three meals daily, and features 24-hour staff and some personal assistance for residents who do not require routine skilled nursing care and would benefit from living in a structured setting. Mount Pleasant Home is a non-smoking facility; no smoking is allowed in the building.

PART A: VITAL INFORMATION

Applicant's Full Name: _____

Person preparing application, if different: _____

Relationship to Applicant: _____

Phone: _____ Email: _____

Other Contact Information: _____

PART B: PERSONAL HISTORY

Previous Addresses: _____

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

If Veteran, list Service Branch: _____ Dates: _____

If Spouse is a Veteran, list Branch: _____ Dates: _____

Citizen? Yes No, Alien Registration #: _____

Primary Language: English Other _____

Current Marital Status:

Married Single Widowed Divorced Separated



PART C: FAMILY & FRIENDS MOST INVOLVED:

Does the Applicant have a legal Power of Attorney, Conservator, or Health Care Proxy currently in place? If so, 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 Effective date: _____

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Healthcare Proxy Effective date: _____

Name: _____

Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Applicant's Parents: *(Full names are necessary for some assistance programs)*

Father's Full Name: _____

Mother's Full Name: _____

Number of Applicant's Children: _____

Names of Applicant's Children: _____



Complete contact information for all children and family members: full name, address, all phone numbers, and e-mail.

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Other Relatives or Interested Friends:

Complete contact information for other relatives/interested friends: full name, address, all phone numbers, and e-mail. Identify any special legal relationship (e.g., power of attorney, conservator, health care proxy).

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____



PART D: BACKGROUND INFORMATION

Education: High School _____

College/Other _____

Occupations: _____

Date Last Employed: _____

Organizational Memberships: _____

Recreation:

Interests and Hobbies: _____

Dining:

Nutritional Requirements and Preferences: _____

Religious Affiliation/Preference: _____

Contact Person and Phone: _____

Funeral & Burial Arrangements:

Cemetery: _____

Deed held by: _____

Burial Insurance (Company/Policy #): _____

Funeral Director: _____

PART E: HEALTH INFORMATION

Physicians

Primary Care Physician: _____

Address: _____ Telephone: _____

Hospital/Clinic: _____



Specialty Physician: _____ Specialty: _____

Address: _____ Telephone: _____

Hospital/Clinic: _____

Care History & Status

Date of last treatment or exam: _____

Details of hospitalization(s) within the last ten years: _____

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

If yes, provide details below, including **Name & Location of Facility**, and Dates of Stay: _____

Do you expect to need assistance with **Personal Care**? No Yes

If yes, explain: _____

Have you ever **smoked** cigarettes, pipes, or cigars? No Yes

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

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? No Yes



Mount Pleasant Home



SEND THIS APPLICATION TO:

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

Info@MountPleasantHome.org

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

We thank you and will contact you shortly!



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.

Provider 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: _____



Physician's Statement

Applicant:

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

Physician:

Mount Pleasant Home is licensed by the Massachusetts Department of Public Health as a long-term care facility and provides housing, meals, support services, and medical oversight in a residential setting. The Home administers medications, schedules medical appointments, serves three meals daily, and features 24-hour staff and some personal assistance for residents who do not require routine skilled nursing care and would benefit from living in a structured setting. Mount Pleasant Home is a non-smoking facility; no smoking is allowed in the building.

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 fill out the following information:

Patient Name: _____ Gender: 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:



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

4. Bathing

- Fully independent
- Needs supervision
- Needs assistance

6. Dressing

- Fully independent
- Needs supervision
- Needs assistance

8. Nutrition Management & Compliance

- Fully independent
- Needs supervision
- Needs assistance

3. Eating

- Fully independent
- Needs supervision
- Needs assistance

5. Toileting

- Fully independent
- Needs supervision
- Needs assistance

7. Grooming/Personal Hygiene

- 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

I approve of _____'s residency at Mount Pleasant Home.

Physician Signature: _____ Date: _____

Physician Name: _____

Hospital/Clinic: _____

Address: _____

Telephone: _____

Email: _____

