



*Susan Bailis*

*Assisted Living*

## RESIDENCY APPLICATION

### General Information

Applicant Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Town/City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ How long at this address? \_\_\_\_\_ years

Telephone where applicant can be reached \_\_\_\_\_

Birth Date \_\_\_\_\_ Birth Place \_\_\_\_\_ Gender  Male  Female

Are you a Veteran?  Yes  No or a spouse/widowed of a Veteran?  Yes  No

Current or former occupation or profession \_\_\_\_\_

Contact information on the person assisting you with the application process (if applicable):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Town/City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

What is your anticipated move-in date? \_\_\_\_\_

What is your preferred apartment?  Studio  One-bedroom apartment

### Current Living Situation

Do you rent or own your home?  Rent  Own Is home listed in applicant's name?  Yes  No

What type of housing do you live in?  Apartment  Single Family  Multi-Family  Condo

Other (please describe) \_\_\_\_\_

Current monthly rental rate \_\_\_\_\_

Name of Landlord/Owner/Manager \_\_\_\_\_ Telephone \_\_\_\_\_

Previous address: \_\_\_\_\_

Are you considering other housing alternatives?  Yes  No

If so, which ones? \_\_\_\_\_

Do you own an automobile?  Yes  No

Do you drive yourself regularly?  Yes  No Do you intend to maintain a car?  Yes  No

## Daily Living

Are there any problems or concerns you would like our staff to be aware of, or any special support you might need to live in our community? \_\_\_\_\_

Do you require someone (friend, relative or other person) to live with you at the present time?

If so, who? \_\_\_\_\_ Reason for this need? \_\_\_\_\_

If not, do you require someone to assist you during the day? \_\_\_ Yes \_\_\_ No

If yes, what type of assistance do you receive? \_\_\_\_\_

Please use an "X" to indicate your desire for assistance in the following areas:

Task	No Assistance Needed	Minimal Assistance Needed	Full Assistance Required
Housekeeping			
Laundry			
Bathing			
Budgeting			
Shopping			
Transportation			
Dressing			
Medication Reminders			
Escort / Mobility			
Night Care			
Shaving / Grooming			

## Health Care Information

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

Hospital Affiliation \_\_\_\_\_

How would you describe your present state of health? \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair

How often do you see your doctor? \_\_\_\_\_ When was your last visit? \_\_\_\_\_

Do you use any assistance such as a cane, walker or wheelchair? \_\_\_ Yes \_\_\_ No Type \_\_\_\_\_

Are you on a special or restricted diet? \_\_\_ Yes \_\_\_ No Please Describe \_\_\_\_\_

Do you smoke? \_\_\_ Yes \_\_\_ No

## Medication and Insurance Information

Are you on any medications at the present time? \_\_\_ Yes \_\_\_ No

If yes, please list the medication(s) and condition(s) being treated:

Medication _____	Condition _____
_____	_____
_____	_____
_____	_____

Please list all of your medical insurance coverage, including Medicare, supplemental and long-term care insurance:

\_\_\_\_\_  
\_\_\_\_\_

## Financial Information

Please provide the following financial information (this information will be kept confidential):

Employment Income	\$ _____	per month
Veterans' Benefits	\$ _____	per month
Social Security Income	\$ _____	per month
Employer Pension	\$ _____	per month
Interest & Dividend Income	\$ _____	per month
Disability Income	\$ _____	per month
Annuity Income	\$ _____	per month
Long Term Care Insurance	\$ _____	per month
Life Insurance Benefits	\$ _____	per month
Contribution from Family	\$ _____	per month
Rental Income	\$ _____	per month
Other:	\$ _____	per month
<b>Total Monthly Income</b>	<b>\$ _____</b>	<b>per month</b>

What are your assets? \_\_\_ CD \_\_\_ Trust \_\_\_ Mutual Fund \_\_\_ Stock/Bond  
\_\_\_ Savings/Checking or \_\_\_ Other \_\_\_\_\_

Do you file tax returns? \_\_\_ Yes \_\_\_ No If yes, please provide a copy of your tax return.

What is the approximate value of your home? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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 me or Susan Bailis Assisted Living unless and until a Residency Agreement has been signed by all parties involved.

I agree to furnish additional financial information as may be required from time to time during my residency and to report any major changes in financial status as soon as possible. During my residency, I will not transfer or reduce those resources that are needed to carry out my commitments to Susan Bailis Assisted Living. I certify that the information contained in this financial statement is true and correct.

---

Signature of Applicant

---

Date of Application

---

Signature of Applicant Representative

---

Date of Application

**Completion of this section is voluntary:**

In order to help us carry out our responsibilities under applicable Fair Housing Laws, we ask that you identify yourself by one of the following designations:

- (Please circle one)    Caucasian            Black / African American            American Indian / Alaskan Native  
                                 Asian            Hispanic / Latino            Other



352 Massachusetts Avenue • Boston, Massachusetts 02115  
Tel 617-247-1010 • Fax 617-247-9595  
[www.susanbailisal.com](http://www.susanbailisal.com)

