CHRISTOPHER HOUSE
OF WORCESTER

10 Mary Scano Drive
Worcester, MA 01605

APPLICATION FOR ADMISSION

NAME: _____ TELEPHONE #: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

DATE OF BIRTH: _____ U.S. CITIZEN: ☐ YES ☐ NO

SEX: M / F MARITAL STATUS: M / S / W / D / SEP NAME OF SPOUSE: _____

RELIGION: _____ HIGHEST LEVEL OF EDUCATION: _____

OCCUPATION: _____

YEAR RETIRED: _____ HOBBIES OR CLUB ASSOCIATIONS: _____

WERE YOU IN THE ARMED FORCES? _____ DATES: _____

FINANCIAL MANAGER

PLEASE STATE THE NAME(S) OF ANY PERSON(S) THAT HANDLE FINANCIAL MATTERS

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

TELEPHONE: _____
HOME CELL WORK

IS THERE A POWER OF ATTY? _____
(PLEASE PROVIDE A COPY WITH THIS APPLICATION) NAME PHONE

PLEASE CHECK TYPE OF AUTHORITY: REPRESENTATIVE PAYEE ☐ CONSERVATOR ☐

LEGAL GUARDIAN ☐ DURABLE POWER OF ATTORNEY ☐

FUNERAL HOME: _____ TYPE: IRREVOCABLE TRUST/BANK ACCOUNT ☐ YES ☐ NO

NAME: _____ ADDRESS: _____ TELEPHONE #: _____

HEALTH CARE PROXY

PLEASE SUBMIT A COPY WITH THIS APPLICATION

NAME: _____ PHONE #: _____

RELATIONSHIP: _____ ADDRESS: _____
STREET CITY STATE ZIP CODE

IS THERE A LEGAL GUARDIAN? ☐ YES ☐ NO NAME: _____

SPOKESPERSON FOR THE APPLICANT

NAME: _____ PHONE #: _____

EMERGENCY CONTACTS

NAME: _____ **ADDRESS:** _____
STREET CITY STATE ZIP CODE

RELATIONSHIP: _____ **PHONE #:** _____
HOME CELL

NAME: _____ **ADDRESS:** _____
STREET CITY STATE ZIP CODE

RELATIONSHIP: _____ **PHONE #:** _____
HOME CELL

NAME: _____ **ADDRESS:** _____
STREET CITY STATE ZIP CODE

RELATIONSHIP: _____ **PHONE #:** _____
HOME CELL

NAME: _____ **ADDRESS:** _____
STREET CITY STATE ZIP CODE

RELATIONSHIP: _____ **PHONE #:** _____
HOME CELL

HEALTH INSURANCE AND INCOME

MEDICARE #: _____ **PART A:** ☐ **PART B:** ☐ **PART D:** ☐ **A&B:** ☐

OTHER HEALTH INSURANCE YOU MAY HAVE
(PLEASE PROVIDE A COPY WITH THIS APPLICATION)

NAME	POLICY NUMBER	$ MONTHLY or QUARTERLY
NAME	POLICY NUMBER	$ MONTHLY or QUARTERLY
NAME	POLICY NUMBER	$ MONTHLY or QUARTERLY

TYPE	RECIPIENT NAME	MONTHLY INCOME
SOCIAL SECURITY		
RETIREMENT (PENSION)		
VA PENSION		
RENTAL INCOME		
ANNUITIES		
OTHER (SPECIFY)		

PLEASE NOTE: IF YOU ARE APPLYING FOR MASS HEALTH (MEDICAID), THE LOOK BACK PERIOD IS 5 (FIVE) YEARS. THIS IS TO DETERMINE WHETHER THERE HAVE BEEN ANY DISQUALIFYING ASSET TRANSFERS.

BANK ACCOUNTS

BANK NAME	ACCOUNT #	NAMES ON THE ACCOUNT	TYPE	$ BALANCE
BANK NAME	ACCOUNT #	NAMES ON THE ACCOUNT	TYPE	$ BALANCE
BANK NAME	ACCOUNT #	NAMES ON THE ACCOUNT	TYPE	$ BALANCE

LIFE INSURANCE

COMPANY NAME	BENEFICIARY	POLICY #	FACE VALUE
COMPANY NAME	BENEFICIARY	POLICY #	FACE VALUE

CURRENT LIVING SITUATION

APPLICANT IS CURRENTLY LIVING AT: _____

DOES APPLICANT LIVE ALONE? ☐ YES ☐ NO WITH WHOM? _____

ADDRESS: _____

CONTACT PERSON: _____ TELEPHONE #: _____

PHYSICIAN: _____ TELEPHONE #: _____

DOES THE APPLICANT NEED HELP? EATING: ☐ BATHING: ☐ GETTING DRESSED: ☐
(PLEASE CHECK ALL THAT APPLY)

DOES THE APPLICANT WALK? INDEP: ☐ USE CANE: ☐ USE W/C: ☐
(PLEASE CHECK ALL THAT APPLY)

IS THE APPLICANT INCONTINENT? BLADDER: ☐ BOWEL: ☐
(PLEASE CHECK ALL THAT APPLY)

DOES THE APPLICANT HAVE MEMORY LOSS? ☐ YES ☐ NO ☐ SHORT TERM ☐ LONG TERM

HAS THE APPLICANT BEEN DIAGNOSED WITH ALZHEIMERS/DEMENTIA? ☐ YES ☐ NO

DOES THE APPLICANT HAVE ANY BEHAVIORS THAT ARE OF CONCERN? ☐ YES ☐ NO

APPLICANT'S PHYSICIAN: _____ ADDRESS: _____

TELEPHONE #: _____

LIST ANY RECENT HOSPITALIZATIONS

HOSPITAL: _____ **APPROX DATE:** _____

HOSPITAL: _____ **APPROX DATE:** _____

IF NOT HOSPITALIZED, PLEASE GIVE DATE OF LAST PHYSICAL EXAM: _____

HAS APPLICANT EVER RESIDED IN A NURSING HOME? ☐ **YES** ☐ **NO**

NAME: _____ **ADDRESS:** _____ **DATE:** _____

HAS APPLICANT EVER BEEN ADMITTED TO A STATE HOSPITAL OR PSYCHIATRIC UNIT? ☐ **YES** ☐ **NO**

NAME: _____ **ADDRESS:** _____ **DATE:** _____

ALCOHOL / TOBACCO USAGE

ALCOHOL USE: ☐ **YES** ☐ **NO**

PRESENT USE: ☐ **YES** ☐ **NO**

PAST USE: ☐ **YES** ☐ **NO**

TOBACCO USE: ☐ **YES** ☐ **NO**

PRESENT USE: ☐ **YES** ☐ **NO**

PAST USE: ☐ **YES** ☐ **NO**

HAS APPLICANT HAD TREATMENT FOR ALCOHOL ABUSE? ☐ **YES** ☐ **NO**

APPLICATION COMPLETED BY: _____

DATE: _____

PLEASE FEEL FREE TO EMAIL THIS APPLICATION TO admissions@christopherhouse.com

ALL APPLICATIONS ARE KEPT ON FILE FOR 1 YEAR FROM DATE OF RECEIPT.