Herbert T. Clark Assisted Living is an elderly affordable assisted living facility. It is a two-story building with 25 one-bedroom apartments. There will be a range of supportive services including 3 meals daily, housekeeping, laundry, activities, and a staff member on-site 24 hours a day. Utopia Assisted Living Inc. will provide the assisted living services including bathing, dressing, medication reminders, homemaking and safety.

The facility is owned by Herbert T. Clark Assisted Living Limited Partnership and managed by Glastonbury Housing Authority. This facility was financed by Connecticut Housing Finance Authority.

Applicants must be 65 or older, and meet the State of Connecticut Home Care for Elders Program's requirements, and must be eligible based upon the household's gross annual anticipated income, using HUD's Section 42 guidelines, to the gross area medium income limits required for this facility.

- All financial documentation must cover **CURRENT INCOME**.
- **All questions must be answered** YES, NO or, if a question does not apply, put N/A.
- Use of "White Out" is prohibited.
- If information must be changed, strike through & initial change.
- Appendix 1 and Inter-Agency Patient Referral Report to be completed by applicant's primary care physician.
- Appendix 2, Appendix 3 & Appendix 4 must be notarized.
- Incomplete applications, including those without proper third party documentation, will not be considered. Please complete and sign the entire application. This application can be returned, **either in the mail** or **in person before 3:00pm Monday through Friday** to Herbert T. Clark House, congregate facility at 45 Canione Road.

When it is determined that the applicant is both program and income eligible, the applicant will:

1. Be required to have a personal interview to review application and financial information.
2. Be required to have a personal interview to review current health status.
3. Be required to have a geriatric assessment with our medical consultant. This is not a physical exam. The expense of the geriatric assessment will be the responsibility of the applicant.

If you have any questions, please call 652-7623.

Herbert T. Clark Assisted Living Facility (Affordable Assisted Living)
Assisted Living Demonstration Pilot Program
43 Canione Road
Glastonbury, CT 06033
(860) 652-7623

Applicant Age and Income – Verification of Eligibility

AGE VERIFICATION

Applicant must meet age eligibility guidelines: Adults 65 years or older; or families of two persons, provided one is at least 65 years of age or older.

Age may be verified with:
A. Copy of a birth certificate, baptismal certificate, census record or official record of birth; or
B. Receipt of SSI Old age benefits or Social Security retirement benefits.

INCOME VERIFICATION

Applicants must meet the income limits according to the requirements of the Low Income Housing Tax Credit Program and the Housing Tax Credit Contribution Program guidelines.

An applicant(s)'s total Gross Family Income from all sources, including net income from assets, is used to determine eligibility.

The income verification period is based on **CURRENT INCOME**.

All income, expenses, assets, household characteristics and circumstances that effect eligibility or tenant rent must be verified and documented.

The following forms of income verification are acceptable:

A. Employment Income:
1. Employment verification form completed by employer.
2. Check stubs or earning statements showing the employee's gross pay per pay period and frequency of pay; or
3. W-2 forms.
4. Notarized statements, affidavits or income tax returns, signed by the applicant describing self-employment and amount of income or income from tips and other gratuities.

B. Social Security, Pensions, Supplemental Security Income (SSI), Disability Income:

1. Benefit verification form completed by agency providing the benefits.
2. Award or benefit notification letters prepared and signed by authorizing agency.

C. Public Assistance:

1. Public Assistance agency's written statements as to type and amount of assistance family is receiving.

D. Alimony or Child Support Payments:

1. Copy of a separation or settlement agreement or divorce decree stating amount and type of support and payment schedules; or
2. A letter from the person paying the support; or
3. Copies of the last three support checks; or
4. Applicant's notarized statement or affidavit of amount received or that support payments are not being received and the likelihood of support payments being received in the future.

E. Net Income from a Business:

1. IRS Tax Return, form 1040, including: Schedule C (Small business); Schedule E (Rental Property Income); or Schedule F (Farm Income); or
2. Audited or unaudited financial statement(s) of the business; or
3. Loan Application listing income derived from the business during the previous 12 months; or
4. Applicants notarized statement or affidavit as to net income realized from his business during the previous years.

F. Recurring Gifts:

1. Notarized statement or affidavit signed by the person providing the assistance. Must give the purpose, dates and value of gifts; or
2. Applicant's notarized statement or affidavit that provides the information in #1.

G. Savings Account Interest Income and Dividends:

1. Account statements, passbooks, certificate of deposit, etc. (should be on official letterhead or copy of official statement, showing account balance or amount of CD, and current interest rate and/or year to date interest);
2. Broker's quarterly statements showing value of stocks or bonds and the earnings credited to the applicant.

H. Interest Income from Sale of Real Property:

1. A letter from an accountant, attorney, real estate broker, the buyer, or a financial institution stating the interest due for 12 months; or
2. Amortization schedule showing interest for 12 months following the effective date of the certification or recertification.

I. Rental Income from Property owned by Applicant:

1. IRS Form 1040 with Schedule E (Rental Income); or
2. Copies of latest rent checks, leases, or other records; or
3. Documentation of applicant's income and expenses in renting the property (tax statements, insurance premiums, receipts for reasonable maintenance and utilities, bank statements or amortization schedules showing monthly interest expense); or
4. Lessee's written statement identifying monthly payments due the applicant and applicant's affidavit as to net income realized.

J. Interest, dividends and other income from Net Family Assets:

A. Net Family Assets include:

1. Cash held in savings and checking accounts, safety deposit boxes, homes, etc.
2. Revocable Trusts – The principal value of any trust available to the household.
3. Equity in rental property or other capital investments(Include the current market value less: 1) Any unpaid balance on any loans secured by the property; and reasonable costs that would be incurred in selling the asset.)
4. Stocks, Bonds, Treasury Bills, Certificates of Deposit, Mutual Funds, and Money Market Accounts.
5. Individual Retirement, 401K and Keogh Accounts.
6. Retirement and pension funds: 1) While the person is employed- include the amounts the family can withdraw; 2) At retirement or termination of employment – If benefits are received in a lump sum, include in Net Family Assets; If benefits are received through periodic payments, include in Annual Income.
7. Lump sum receipts – Inheritances, capital gains, one-time lottery winnings, settlements on insurance or other claims.
8. Personal property held as an investment (i.e. gems, jewelry, coin collections or antique cars).

B. Net Family Assets do not include:

1. Necessary personal property
2. Vehicles specially equipped for the handicapped.
3. Life Insurance policies.
4. Equity in the cooperative unit in which the applicant lives.

5. Assets that are part of an active business.
6. Assets that are not effectively owned by the applicant.
7. Assets that are not accessible to the applicant and provide no income to the applicant.

C. Value of Net Family Assets are based on the <u>cash value</u>* of the asset.

D. The following documentation of assets is acceptable:

1. Verification form, letters, or documents from a financial institution, broker, etc.
2. Passbooks, checking account statements, certificates of deposit, bonds, or financial statements completed by a financial institution or broker.
3. Quotes from a stock broker or realty agent as to net amount family would receive if they liquidated securities or real estate.
4. Real Estate tax statements if tax authority uses approximate market value.
5. Copies of closing documents showing selling price, the distribution of the sales proceeds and the net amount to the borrower.
6. Appraisals of personal property held as an investment.
7. Applicant's notarized statements or signed affidavits describing assets or verifying cash held at the applicant's home or in safe deposit boxes.

E. <u>Imputed income from assets</u>:

If the family assets exceed $5000, the income from the assets must be calculated at the <u>greater</u> of the following:

Actual income from the assets; or a percentage of the value of family assets based upon the current passbook savings rate as established by HUD. This is called *imputed* income from assets.

***CASH VALUE IS THE MARKET VALUE LESS REASONABLE EXPENSES THAT WOULD BE INCURRED IN SELLING OR CONVERTING THE ASSEST TO CASH.**

Herbert T. Clark Assisted Living - managed by the Housing Authority of the Town of Glastonbury
43 Canione Road, Glastonbury, CT 06033

APPLICATION FOR HOUSING

Low-Income Housing Tax Credit Property/ Assisted Living

Please Print Clearly

This is an application for housing at:	**Project: Herbert T. Clark Assisted Living** **Address: 43 Canione Road** **Glastonbury, CT 06033**
Please complete this application and return to:	**Name: Herbert T. Clark Congregate Housing** **Address: 45 Canione Road** **Glastonbury, CT 06033**

Applications are placed in order of date and time received. An applicant may be interviewed only after the receipt of this tenant application.

A. GENERAL INFORMATION

Applicant Name(s): _____

Address: _____
Street Apt.# City State ZIP

Daytime Phone: _____ Evening Phone: _____

No. of BR's in current unit: _____ Do you ☐ RENT or ☐ OWN (check one)

Amount of current monthly rental or mortgage payment: $ _____

If owned, do you receive monthly rental income from property? ☐ Yes ☐ No (check one)

Check utilities paid by you: ☐ Heat ☐ Electricity ☐ Gas ☐ Other (specify)

Approximate monthly cost of utilities paid by you (excluding phone and cable TV): $ _____

Bedroom size requested: ☐ Studio ☐ One BR ☐ Two BR ☐ Three BR ☐ Handicap BR

B. HOUSEHOLD COMPOSITION

List ALL persons who will live in the apartment. List the head of household first.

	Name (Last, First, M.I.)	Relationship to head H – head of household S - spouse A - adult co-tenant C - child F – foster child(ren)/adult(s) O - other family member L - live-in caretaker N – none of the above	Marital Status M--married D--divorced S--single L--legal separation E--estranged	Birth Date (mm/dd/yyyy)	Age	SS# or Alien Reg. #	Student Y/N	Sex M/F	Race 1--white 2--black 3--hispanic 4--other
Head									
Co-T									
3.									
4.									
5.									
6.									
7.									
8.									

Do you anticipate any additions to the household in the next twelve months? ☐ Yes ☐ No

If yes, explain:

Will any of the persons in the household be or have been full-time students during five calendar months of this year or plan to be in the next calendar year at an educational institution (other than a correspondence school) with regular faculty and students? ☐ Yes ☐ No

IF YES, ANSWER THE FOLLOWING QUESTIONS:

Are any full-time student(s) married and filing a joint tax return?	☐ Yes	☐ No
Are any student(s) enrolled in a job-training program receiving assistance under the Job Training Partnership Act?	☐ Yes	☐ No
Are any full-time student(s) a TANF or a title IV recipient?	☐ Yes	☐ No
Are any full-time student(s) a single parent living with his/her minor child who is not a Dependant on another's tax return?	☐ Yes	☐ No

C. INCOME

List ALL sources of income as requested below. If a section doesn't apply, cross out or write NA.

Household Member Name	Source of Income	Gross Monthly Amount
	Social Security	$
	Social Security	$
	Social Security	$
	Social Security	$
	SSI Benefits	$
	SSI Benefits	$
	SSI Benefits	$
	SSI Benefits	$
	Pension (list source)	$
	Pension (list source)	$
	Pension (list source)	$
	Veteran's Benefits (list claim #)	$
	Veteran's Benefits (list claim #)	$
		$
	Unemployment Compensation	$
	Unemployment Compensation	$
	Title IV/TANF	$
	Title IV/TANF	$
	Title IV/TANF	$
	Full-Time Student Income (18 & Over Only)	$
	Full-Time Student Income (18 & Over Only)	$
	Interest Income (source)	$
	Interest Income (source)	$
	Interest Income (source)	$
	Interest Income (source)	$

Household Member Name	Source of Income	Monthly Amount
	Employment amount	$
	Employer:	
	Position Held	
	How long employed:	
	Employment amount	$
	Employer:	
	Position Held	
	How long employed:	
	Employment amount	$
	Employer:	
	Position Held	
	How long employed:	
	Employment amount	$
	Employer:	
	Position Held	
	How long employed:	
	Alimony	
	Are you ***entitled*** to receive alimony?	☐ Yes ☐ No
	If yes, list the amount you are ***entitled*** to receive.	$
	Do you receive alimony?	☐ Yes ☐ No
	If yes, list amount you receive.	$
	Child Support	
	Are you ***entitled*** to receive child support?	☐ Yes ☐ No
	If yes, list the amount you are ***entitled*** to receive.	$
	Do you receive child support?	☐ Yes ☐ No
	If yes, list the amount you receive.	$
	Other Income	$
	Other Income	$
	Other Income	$
TOTAL GROSS ANNUAL INCOME (Based on the monthly amounts listed above x 12)		$
TOTAL GROSS ANNUAL INCOME FROM PREVIOUS YEAR		$
Do you anticipate any changes in this income in the next 12 months?	☐ **Yes**	☐ **No**
If yes, explain:		

D. ASSETS

If your assets are too numerous to list here, please request an additional form.
If a section doesn't apply, cross out or write NA.

Checking Accounts	#	Bank	Balance $
	#	Bank	Balance $
	#	Bank	Balance $
Savings Accounts	#	Bank	Balance $
	#	Bank	Balance $
	#	Bank	Balance $
Trust Account	#	Bank	Balance $
Certificates	#	Bank	Balance $
	#	Bank	Balance $
	#	Bank	Balance $
	#	Bank	Balance $
Credit Union	#	Bank	Balance $
	#	Bank	Balance $
Savings Bonds	#	Maturity Date	Value $
	#	Maturity Date	Value $
	#	Maturity Date	Value $
Life Insurance Policy	#		Cash Value $
Life Insurance Policy	#		Cash Value $

Mutual Funds	Name:	#Shares:	Interest or Dividend $	Value $
	Name:	#Shares:	Interest or Dividend $	Value $
	Name:	#Shares:	Interest or Dividend $	Value $
Stocks	Name:	#Shares:	Dividend Paid $	Value $
	Name:	#Shares:	Dividend Paid $	Value $
	Name:	#Shares:	Dividend Paid $	Value $
Bonds	Name:	#Shares:	Interest or Dividend $	Value $
	Name:	#Shares:	Interest or Dividend $	Value $
Investment Property				Appraised Value $

Real Estate Property: ***Do you own any property?***	☐ Yes ☐ No
If yes, type of property	
Location of property	
Appraised Market Value	$
Mortgage or outstanding loans balance due	$
Amount of annual insurance premium	$
Amount of most recent tax bill	$

Have you sold/disposed of any property in the last 2 years?	☐ Yes ☐ No
If yes, type of property	
Market value when sold/disposed	$
Amount sold/disposed for	$
Date of transaction	

Have you disposed of any other assets in the last 2 years (Example: Given away money to relatives, set up Irrevocable Trust Accounts)?	☐ Yes ☐ No
If yes, describe the asset:	
Date of disposition	
Amount disposed	$

Do you have any other assets not listed above (excluding personal property)?	☐ Yes ☐ No
If yes, please list _____	

E. ADDITIONAL INFORMATION

Are you or any member of your family currently using an illegal substance?	☐ Yes	☐ No
Have you or any member of your family ever been convicted of a felony?	☐ Yes	☐ No
If yes, describe:		
Have you or any member of your family ever been evicted from any housing?	☐ Yes	☐ No
If yes, describe:		
Have you ever filed for bankruptcy?	☐ Yes	☐ No
If yes, describe:		

Will you take an apartment when one is available?	☐ Yes	☐ No
Briefly describe your reasons for applying:		

F. REFERENCE INFORMATION

Current Landlord	Name:	
	Address:	
	Home Phone:	
	Bus. Phone:	
	How Long?	
Prior Landlord	Name:	
	Address:	
	Home Phone:	
	Bus. Phone:	
	How Long?	

Credit Reference #1:	
Address:	
Account #:	Phone #:
Credit Reference #2:	
Address:	
Account #:	Phone #:
Credit Reference #3:	
Address:	
Account #:	Phone #:
Personal Reference #1:	
Address:	
Relationship:	Phone #:
Personal Reference #2:	
Address:	
Relationship:	Phone #:
Personal Reference #3:	
Address:	
Relationship:	Phone #:

In case of emergency notify:	
Address:	
Relationship:	Phone #:

G. VEHICLE AND PET INFORMATION (if applicable) List any cars, trucks, or other vehicles owned. Parking will be provided for one vehicle. Arrangements with Management will be necessary for more than one vehicle.			
Type of Vehicle:	License Plate #:		
Year/Make:	Color:		
Type of Vehicle:	License Plate #:		
Year/Make:	Color:		
Do you own any pets?		Yes	No
If yes, describe:			

CERTIFICATION

I/We hereby certify that I/We Do/Will Not maintain a separate subsidized rental unit in another location. I/We further certify that this will be my/our permanent residence. ~~I/We understand I/We must pay a security deposit for this apartment prior to occupancy.~~ I/We understand that my eligibility for housing will be based on applicable income limits and by management's selection criteria. I/We certify that all information in this application is true to the best of my/our knowledge and I/We understand that false statements or information are punishable by law and will lead to cancellation of this application or termination of tenancy after occupancy. All adult applicants, 18 or older, must sign application.

SIGNATURE (S):

_____ _____
(Signature of Tenant) Date

_____ _____
(Signature of Co-Tenant) Date

_____ _____
(Signature of Co-Tenant) Date

_____ _____
(Signature of Co-Tenant) Date

AUTHORIZATION for Release of Information

CONSENT

I authorize and direct any Federal, State, or local agency, organization, business, or individual to release and to verify my application for participation, and/or to maintain my continued assistance under the Section 8, Rental Rehabilitation, Low-Income Public and Indian Housing and/or any other housing assistance programs. I understand and agree that this authorization or the information obtained with its use may be given to and used by the U.S. Department of Housing and Urban Development (HUD) in administering and enforcing program rules and policies. I also consent for HUD or the PHA to release information from my file about my rental history to HUD, credit bureaus, collection agencies, or future landlords. This includes records on my payment history, and any violations of my lease or PHA policies.

INFORMATION COVERED

I understand that, depending on program policies and requirements, previous or current information regarding me or my household may be needed. Verifications and inquiries that may be requested include but are not limited to:

Identity and Marital Status
Medical or Child Care Allowances
Residences and Rental Activity
Employment, Income and Assets
Credit and Criminal Activity

GROUP OR INDIVIDUAL THAT MAY BE ASKED

The groups or individuals that may be asked to release the above information (depending on program requirements) include but are not limited to:

Previous Landlords (including Public Housing Agencies
Courts and Post Offices
Schools and Colleges
Law Enforcement Agencies
Medical and Child Care Providers
Retirement Systems
Utility Companies
Past and Present Employers
Welfare Agencies
State Unemployment Agencies
U.S. Social Security Administration
Support and Alimony Providers
U.S. Department of Veterans Affairs
Banks and Other Financial Institutions
Credit Providers and Credit Bureaus

COMPUTER MATCHING NOTICE AND CONSENT

I understand and agree that HUD or the Public Housing Authority may conduct computer matching programs to verify the information supplied for my application or recertification. If a computer match is done, I understand that I have a right to notification of any adverse information found and a chance to disprove correct information. HUD or the PHA may in the course of its duties exchange such automated information with other Federal, State or local agencies, including but not limited to: State Employment Security Agencies, U.S. Department of Defense, U.S. Office of Personnel Management, the U.S. Postal Service, the U.S. Social Security Administration, and State welfare and food stamp agencies.

CONDITIONS

I agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization will remain on file with the PHA. I understand I have a right to review my file and correct any information that I can prove is incorrect.

SIGNATURES:

Head of Household	(Print Name)	(Date)
Spouse	(Print Name)	(Date)
Adult Member	(Print Name)	(Date)
Adult Member	(Print Name)	(Date)

NOTE: THIS GENERAL CONSENT MAY NOT BE USED TO REQUEST A COPY OF A TAX RETURN. IF A COPY OF TAX RETURN IS NEEDED, IRS FORM 4506, "REQUEST FOR COPY OF TAX FORM" MUST BE PREPARED AND SIGNED SEPARATELY.

WAITING LIST POLICY

I understand that once you have reviewed my application and I am found eligible for housing at the Herbert T. Clark Assisted Living Facility per requirements of the Connecticut Home Care Program through the Department of Social Services and HUD Section 42 Guidelines, my name will be placed on your waiting list based on chronological order of date and time when application was received. I also understand that at the time that an apartment becomes available, my financial information will need to be recertified.

Applicants for the Herbert T. Clark Assisted Living Facility are required to maintain an address where they can be contacted. Periodically, mailings are made to applicants as well. At least once a year, a purge of the waiting list is made. If during the course of purging the list or mailing information, items are sent and returned to the Herbert T. Clark Assisted Living Facility of the Housing Authority of the Town of Glastonbury, THE APPLICANT WILL BE DROPPED FROM THE WAITING LIST. Any applicant so dropped may reapply if the waiting list is open, but if permitted to apply, he or she will be placed at the bottom of the list.

Applicant's Signature_____Date_____

Spouse's Signature _____Date_____

Date:	Time:	Herbert T. Clark Assisted Living Representative Initial here:

Herbert T. Clark Assisted Living
43 Canione Road
Glastonbury, CT 06033
Phone: (860) 652-7623 Fax: (860) 652-7632

PHYSICIAN'S REPORT – APPENDIX 1

Patient's Name_____Age_____
Address:_____
City:_____State:_____Zip Code_____

Dear Doctor,

Your patient wishes to join us at the Herbert T. Clark Assisted Living Facility. As you know, Assisted Living is a special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help with activities of daily living. This facility provides individual accommodations with private kitchen and bath facilities; three meals a day; housekeeping services; weekly laundry services; and a staff member on site 24 hours a day. In addition, your patient will be receiving assisted living services from a licensed Assisted Living Services Agency (ALSA).

As part of the application process, we need a physician report completed. We ask that you complete each item on this form and return it to us with any other pertinent comments you deem appropriate. The confidential information you provide will be used by our professional staff during our assessment for eligibility and used by the ALSA provider to identify the appropriate level of assisted living services, and to initiate a care plan.

It is important that each resident be chronic and stable. These services are designed to help provide assistance to residents who need additional help, but do not need a skilled nursing facility. The resident will need to be able to maintain him/herself in an independent manner without endangering either themselves or others in order to benefit from our facility. It is equally important that each resident be emotionally stable, suited to and capable of close community living, since the welfare and peace of mind of many residents are involved. This information is CONFIDENTIAL. If you have any questions, please feel free to call Wendy Ehrhardt at (860) 652-7623. Thank you in advance for your cooperation.

Date of Birth:_____ Date of Last Office Visit: _____

Drug or other allergies: _____

Does your patient have a history of:

		Comments or Medications/Dosage
Alzheimer's Disease	No____ Yes____	_____
Asthma or Allergy	No____ Yes____	_____
Cancer	No____ Yes____	_____
Cerebrovascular	No____ Yes____	_____
Dementia	No____ Yes____	_____
Depression	No____ Yes____	_____
Diabetes	No____ Yes____	_____
Emphysema	No____ Yes____	_____
Epilepsy	No____ Yes____	_____
Gastrointestinal	No____ Yes____	_____
Glaucoma	No____ Yes____	_____
Heart Disease	No____ Yes____	_____
Hypertension	No____ Yes____	_____
Kidney Disease	No____ Yes____	_____
Liver Disease	No____ Yes____	_____
Osteoporosis	No____ Yes____	_____
Parkinson's Disease	No____ Yes____	_____
Respiratory Disease	No____ Yes____	_____
Thyroid Disease	No____ Yes____	_____

Current or recent (within 6 months) problems with:

Arthritis	No_____ Yes_____
Appetite, poor	No_____ Yes_____
Chronic back	No____ Yes_____
Fainting	No_____ Yes_____
Falls	No_____ Yes_____
Fatigue	No_____ Yes_____

Indigestion	No_____ Yes_____
Jaundice	No_____ Yes_____
Loss of weight	No_____ Yes_____
Nausea or Vomiting	No_____ Yes_____
Paralysis	No_____ Yes_____
Psychiatric illness	No_____ Yes_____
Seizures	No_____ Yes_____
Urinary retention	No_____ Yes_____
Urinary Incontinence	No_____ Yes_____

Hospitalizations: (During the past 5 years)

Dates: **Cause:**

_____

_____

_____

_____

_____

_____

_____

Medical History:

Regarding the questions below: If "yes" or "no" provides adequate meaning, please use it. If a descriptive phrase will convey more useful information, we would appreciate the phrase.

Regarding your Patient:

a. Do you detect any condition or disease that would require care from a skilled Long-term facility at this time?_____

b. Is your patient's medical condition chronic and stable and are they able to live independently?

_____

c. Does your patient have the physical and mental ability to exit the facility without assistance, or requires limited assistance, such as the use of a walker, wheelchair, cane, prosthetic device or a single verbal command in an emergency?

Yes_____ No _____

d. Does your patient need a cane, walker, wheelchair or electric cart for mobility?

_____

e. What diet is appropriate for your patient?

Regular_____ Mechanical Soft _____ Puree_____

f. Does your patient have swallowing difficulties? _____

g. Does your patient take any dietary supplements? _____

h. Is he/she able to feed self? _____

i. Is your patient capable of administering his/her own medications?_____

j. What is a normal blood pressure range for your patient? _____

k. What is a normal pulse range for your patient?_____

l. Describe in detail any visual problems or progressive eye disease?

_____

_____

m. Describe in detail any hearing problems. _____

n. Does your patient have a hearing device? _____

o. Is there any history of drug or alcohol addiction? _____

p. Does your patient have use of a heart pacer? _____

q. Do you detect any condition or disease in your patient that might impair health or comfort of other residents? _____

*** *Do you feel that your patient is capable of living in our assisted living facility? ****

_____

Tuberculosis Screening Evaluation

Date and result of most recent Mantoux tuberculin skin test:

Date: _____/_____/_____ mm of indication_____

Check here if previously positive and above information unknown: _____

Check here if exhibiting TB-like symptoms: ____

If TB skin test result is 10mm or greater (5mm in the HIV infected), previously positive or if TB-like symptoms exist, respond to the following:

a. Date of last chest x-ray evaluation: ____/____/____.

b. Are chest x-rays suggestive of active TB? Yes_____ No_____

c. Were sputum smears collected and analyzed for the presence of acid fast bacilli (AFB)?

Yes_____ No_____

d. If #c is Yes, were three consecutive smears negative for AFB?

Yes_____ No_____

Based on the above information, is this individual free of communicable TB?

Yes_____ No_____

****

I have completed the medical history section, and I have determined that my patient_____ may require the Services of a Home Care Agency for any Medicare reimbursable service and also qualifies for ALSA services.

_____ _____

Physician's Signature Physician's Name Printed

_____

Date

✦ **Applicants, Families, and Physicians:**

This report may need to be updated due to the availability of an apartment.

Thank you,

Wendy K. Ehrhardt, Director

Herbert T. Clark Assisted Living

GHA Representative_____ Date Received _____

INTER-AGENCY PATIENT REFERRAL REPORT

W-10 REV. 9/83

STATE OF CONNECTICUT DEPT. OF INCOME MAINTENANCE-Health Services

IDENTIFYING DATA

PATIENT'S NAME (Last, First, Middle)	SEX	BIRTH DATE	ADMISSION DATE	DISCHARGE DATE

PATIENT'S HOME ADDRESS (No. and Street, Town or City, State, Zip Code)	HOME PHONE NO.	MARITAL STATUS	RELIGION

RESPONSIBLE PERSON OR AGENCY (Name and Address)	TELEPHONE NO.

REFERRED BY (Name and Address of Facility or Agency)	CONTACT PERSON OR UNIT	TELEPHONE NO.

REFERRED TO (Name and Address of Facility or Agency)	CONTACT PERSON OR UNIT	TELEPHONE NO.
06512 Utopia Assisted Living, 665 Foxon Rd, E. Haven, CT	Marijayne Sargent	(860) 305-9136

FOLLOW-UP BY (Name and Address of Physician or Clinic)	TELEPHONE NO.	DATE OF NEXT APPOINTMENT
1.		
2.		

MEDICAL RECORD NO.	MEDICARE NO.	SOCIAL SECURITY NO.	DEPT. OF INC. MAINT. NO.	OTHER

PERTINENT HISTORY (Include dates of diagnosis and problems) AND PLAN OF CARE (Include treatment, diet, activity permitted)

ALSA services to be provided as assessed by RN. Client condition is chronic & stable yes ☐ No ☐

PATIENT CARE INFORMATION

MEDICATIONS (Drug, Strength, Mode)	FREQUENCY	LAST GIVEN	MEDICATIONS (Drug, Strength, Mode)	FREQUENCY	LAST GIVEN
1.			2.		
3.			4.		
5.			6.		
7.			8.		

ALLERGIES	DIAGNOSIS GIVEN	EXPLAINED TO	PROGNOSIS	EXPLAINED TO
		☐ Patient ☐ Family		☐ Patient ☐ Family

THERAPEUTIC GOALS

PATIENT SERV. START DATE	SERVICES REQUESTED
	☐ Nursing ☐ Occ. therapy ☐ Speech therapy ☐ Physical therapy ☐ H. H. aide ☐ Social work ☐ Other (specify) ALSA

IS TREATMENT FOR CONDITION FOR WHICH PATIENT WAS HOSPITALIZED (If NO explain)	PATIENT ESSENTIALLY HOMEBOUND
☐ Yes ☐ No	☐ Yes ☐ No

I HEREBY CERTIFY THAT THE ABOVE SERVICES SHOULD BE PROVIDED BY	SIGNED (Physician)	DATE SIGNED
☐ Acute Hosp. ☐ Chronic Hosp. ☐ SNF ☐ ICF ☐ Home Health Agy. ☐ Rehab. Center		

Herbert T. Clark Assisted Living
43 Canione Road
Glastonbury, CT 06033
Phone: (860) 652-7623 Fax: (860) 652-7632

APPENDIX 2

SPONSOR STATEMENT

I, _____, the undersigned, agree to be responsible for the care of _____. My responsibilities will include being the contact person in case of problems or emergencies regarding _____ and assisting the Director of the Herbert T. Clark Assisted Living Facility during these problems or emergencies, if I am requested.

Further, I understand that if _____ becomes incapable of independent living due to increased disability either physically or mentally, as determined by the Housing Authority of the Town of Glastonbury, I will be totally responsible for relocating _____ to a facility better suited for his/her needs.

Furthermore, I understand that I am not responsible for any financial obligations.

My responsibilities are to provide for the care of _____ when necessary.

I agree to notify the Glastonbury Housing Authority if there should be any change in the above information.

Date _____ Signature _____

Acknowledged and sworn, before me, this _____ day of _____, 20_____.

_____ (Seal)
Notary Public

GHA Representative_____ Date Received _____

2/2004

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Glastonbury, CT 06033
Phone: (860) 652-7623 Fax: (860) 652-7632

APPENDIX 3

APPLICANT/TENANT INFORMATION AUTHORIZATION STATEMENT

I understand that the Housing Authority of the Town of Glastonbury is required by State Law to verify income and information relative to the person(s) applying for admission to the Herbert T. Clark Assisted Living Facility and to re-examine annually the income of all person(s) for continued occupancy.

I hereby authorize the Housing Authority of the Town of Glastonbury to obtain verification of information concerning my financial income, assets, landlord references, and credit references relative to my application for admission to the Herbert T. Clark Assisted Living Facility and re-examination for continued occupancy.

In addition, I authorize the release of information regarding character references and medical history, including disability, frequency and duration of treatment, and information required to establish evidence of rehabilitation, or my ability to independently maintain my apartment.

This authorization will continue in full force and effect until terminated, in writing, by the undersigned.

Date_____ Signature _____

Date _____ Signature _____

Acknowledged and sworn before me, this _____ day of _____, 20_____.

_____ (Seal)
Notary Republic

GHA Representative _____ Date Received _____

2/2004

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Glastonbury, CT 06033
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APPENDIX 4

RESIDENT STATEMENT

I, _____, the undersigned, understand that the Herbert T. Clark Assisted Living Facility is for the frail elderly, capable of independent living, who require assisted living services to continue to maintain their independence.

I agree and understand that at such time I am not capable of independent living and require more services and assistance than is available in the Herbert T. Clark Assisted Living Facility due to increased disability, either physically or mentally, as determined by the Glastonbury Housing Authority, I will make the necessary arrangements to move to a facility that will better suit my needs.

Further, I will notify the Director of the Herbert T. Clark Assisted Living Facility of my plans for relocation by the first of the month prior to the month of my anticipated vacancy so my record, and the records of the Glastonbury Housing Authority may be updated.

Date _____ Signature _____

Date _____ Signature _____

Acknowledged and sworn, before me, this _____ day of _____, 20_____.

_____
Notary Public (Seal)

GHA Representative _____ Date Received _____

2/2004

NON-EMPLOYMENT AFFIDAVIT

Applicant Name :_____ **SSN :** _____
Address :_____ **Phone :**_____
City, State, Zip :_____

Our assisted living facility provides affordable housing under Section 42 of the Internal Revenue Code. Households applying for occupancy are required to disclose their employment status and future intentions for purposes of determining income eligibility.

Who should complete this form: If you are age 18 or older or an emancipated minor, you need to certify whether or not you have disposed of any assets for less than fair market value in the past 2 years.

We are required to inform you that intentionally supplying false information is punishable under the Statute of Frauds.

The US Government requires the following:

- All questions, must be answered YES, NO or, if a question does not apply, put N/A.
- If uncertain, use best available information.
- Use of "White out" is prohibited.
- If information must be changed, strike through & initial change.
- Signature and date of person completing this form is required.

Choose the appropriate numbered statement below:

____1. I am not currently employed and I do not intend on becoming employed in the next twelve months due to: (Please check one)

(a)_____I am currently receiving unemployment benefits.
(b)_____I am **not** currently receiving but **do anticipate** receiving unemployment benefits.
(c)_____I am not currently receiving and **do not anticipate** receiving unemployment benefits.

_____2. I am not currently employed but I anticipate becoming employed in the next 12 months. I have accepted a position with _____(employer) that will begin on _____ (date).

_____3. Other (explain):

_____

By my signature below, I certify the above representations to be true as of the date shown below. I further understand and agree that any misrepresentation herein will be considered a material breach of my lease agreement and could lead to eviction, financial and other penalties. Prior to move in, I will notify management of any changes to these circumstances.

_____ _____
Applicant Signature Date

Subscribed and sworn to me under oath this _____ day of _____, _____.

_____
Printed Name of Notary Public

_____
Signature of Notary Public

Notary Public, State of _____. My commission expires on _____, _____.

Please return completed form to our office.