

Saint Elizabeth Court
Assisted Living Residence
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401-490-4646

Application for Residency

Saint Elizabeth Court
Just like family



109 Melrose Street
Providence, Rhode Island 02907

phone: 401. 490. 4646
fax: 401. 490. 4537

www.stelizabethcommunity.org

PART 1: General Information

Thank you for expressing interest in residency at Saint Elizabeth Court. Please complete and return this initial form at your earliest convenience.

Applicant Name _____ Social Security# _____

Address _____ Town/City _____

State _____ Zip _____ How long _____ Telephone (applicant) _____

Email (friend or family) _____

Birth Date _____ Birth Place _____ sex male ___ Female ___

Marital Status _____

Current or former occupation or profession _____

Are you a current student? ___yes ___no ___part-time ___full-time

Completion of this section is voluntary:

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

Race: White ___ African American ___ Asian ___ Native American ___ Hispanic ___ Other ___

Ethnicity: Hispanic ___ Non Hispanic ___

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Contact Information on the person assisting you as you consider Saint Elizabeth Court

Name _____ Relationship _____

Address _____ Town/City _____

State _____ Zip _____ Home Telephone _____

Cell Telephone _____ Work Telephone _____

Responsible Party for financial purposes _____

Relation _____ Telephone _____

Email _____

Do you wish to receive the monthly newsletter electronically? Yes _____ no _____

Do you wish to receive the monthly statement electronically? Yes _____ no _____

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PART 2: CURRENT LIVING SITUATION

Do you own or rent your home? ___Own ___Rent

Is the home listed in applicant's name? ___Yes ___No

What type of housing do you live in? ___Apartment ___Single Family ___Multi-Family___Condo___Other

Current monthly rental rate?_____

Name of Landlord/Owner/Manager _____Telephone_____

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

___Yes ___No If so, who_____

Reason for the need_____

If not, do you require someone to visit you during the day? _____Yes _____No

Does anyone have Power of Attorney for you? Health ___Yes ___No financial ___Yes ___No

If Yes: Name_____Address_____

Home **Tel:**_____Work **Tel:**_____Cell **Tel:**_____

Relationship _____

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PART 3: MEDICAL AND INSURANCE INFORMATION

Physician's Name _____

Address _____ Telephone# _____ Fax _____

Hospital Preference _____

How would you describe your present health? _____

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

Are you on any medications at the present time? _____yes _____no

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

Medication _____	_____
_____	_____
_____	_____
_____	_____

Do you use any assistance such as a cane, walker or wheelchair? _____yes _____no

Do you Smoke? _____yes _____no

Please list all of your medical insurance coverage, including Medicaid, supplemental and long term care insurance.

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PART 4: DAILY LIVING

Please use an (x) to indicate your level of ability in the following areas:

Task	Independent	Some Assistance	Dependent
Preparing Meals	_____	_____	_____
Housekeeping	_____	_____	_____
Laundry	_____	_____	_____
Bathing	_____	_____	_____
Fire Safety	_____	_____	_____
Budgeting	_____	_____	_____
Shopping	_____	_____	_____
Transportation	_____	_____	_____
Dressing	_____	_____	_____
Medications	_____	_____	_____
Walking	_____	_____	_____

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PART 5: FINANCIAL INFORMATION

The following worksheet is necessary to determine how your financial resources will cover the monthly living costs at Saint Elizabeth Court. (This information is kept confidential)

Employment Income	\$ _____ per month
Social Security Income	\$ _____ per month
Employer Pension	\$ _____ per month
Interest and Dividend Income	\$ _____ per month
Annuity Income	\$ _____ per month
Life Insurance Benefits	\$ _____ per month
Support from Family	\$ _____ per month
Rental Income	\$ _____ per month
VA Benefits	\$ _____ per month
Spousal Income	\$ _____ per month
Total Monthly Income	\$ _____ per month

Is the value of your total assets (including home ownership, savings, CDs, etc)

Below or above two thousand dollars (\$2000.00)? Below Above

Estimated Values _____

Do you own any property? Yes No

Have you sold or disposed of any property or assets in the last 2 years? Yes No

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

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I understand and agree that this application is neither a contract, nor a reservation for residency. Nothing contained in this document is legally binding to my self or Saint Elizabeth Court until a Residency Agreement has been signed by all parties involved.

Signature of Applicant

Date of Application

AN AGGRIEVED PERSON MAY FILE A COMPLAINT OF A HOUSING DISCRIMINATION ACT WITH:

R.I Housing and Mortgage Finance Corporation

**44 Washington Street
Providence, RI 02903
TEL: 401-751-5566**

**U.S. Department of Housing &
Urban Develop**

**10 Weybosset Street
Providence, RI 02903
Tel: 401-528-4855**