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# Application for Residency



**1200 Wright Avenue, Alma, MI**

**1-800-321-9357**

**[www.masonicpathways.com](http://www.masonicpathways.com)**

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# Application for Residency

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## Demographic Information

**Full Name:** \_\_\_\_\_

(First, Middle, Last as it appears on birth certificate)

**Nickname:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_

Street City State Zip

**Are you a current Michigan resident?**  
Yes No

**Since when?** \_\_\_\_\_

**Are you a U.S. citizen?**  
Yes No

**City of Birth:** \_\_\_\_\_ / **County:** \_\_\_\_\_

**Ethnicity:** American Indian Asian African American Caucasian Hispanic Other

**Marital Status:** Single Married Separated Divorced Widowed

**Wedding Anniversary Date:** \_\_\_\_\_ **Retirement Date:** \_\_\_\_\_

**Spouse's Name:** \_\_\_\_\_ **Spouse's Birthdate:** \_\_\_\_\_

**Are you a veteran, or the spouse of a veteran, of the U.S. Armed Services?**  
Yes No

**Service branch:** \_\_\_\_\_

**Dates of service:** \_\_\_\_\_

**Do you currently receive Veteran's Benefits?**  
Yes No

**Veteran's number:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

**Mother's Maiden Name:** \_\_\_\_\_

**Primary Occupation Prior to Retirement:** \_\_\_\_\_

**Check the statement that best describes your current living arrangement.**

I live alone in my own home.	
I live with my spouse in my own home.	
I live with a family member in his or her home.	
I live alone in a rental home.	
I live with my spouse in a rental home.	
I live in an Adult Foster Care or Assisted Living center.	
I live in a Skilled Nursing Facility.	
Name of Facility:	
Address: _____ Phone: _____	
Name of Case Manager:	
I receive visiting assistance ____ hours per day/ week in my own home or rental home.	

**Masonic Affiliation**

**Yes**

**No**

	Yes	No
Are you currently a member of a Michigan Lodge of the Free and Accepted Masons?		
Are you currently a member of a Michigan Chapter of the Order of the Eastern Star?		
Are you the wife, widow, or mother of a member of a Michigan Lodge of the Free and Accepted Masons?		

Lodge/Chapter Name: \_\_\_\_\_

Lodge/Chapter Number: \_\_\_\_\_

Applicant's relationship to member: \_\_\_\_\_

# Health Care Insurance

Policy Name	Policy Name & Number	Policy Holder & Number	Policy Holder Date of Birth
Medicare Part A      YES NO Part B      YES NO			
Medicare Advantage Part C      YES NO			
Medicare Prescription Plan Part D      YES NO			
Prescription Plan (Other than Part D) Plan Name _____ _____			
Medicaid              YES NO			
Blue Cross Blue Shield              YES NO			
Other (i.e. Tri-Care, VA, Coal Miners, etc.)              YES NO			

## Legal Information

Has the court appointed a Guardian or Conservator for you?      **Yes**              **No**

Name of Guardian or Conservator: _____	
Address: _____ _____ City, ST, Zip Phone: _____	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;">                     Please attach a signed copy of the document.                 </div>

Do you have a Durable Power of Attorney for Health Care?      **Yes**              **No**

Name of DPOA for Health Care: _____	
Address: _____ _____ City, ST, Zip Phone: _____	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;">                     Please attach a signed copy of the document.                 </div>

Do you have a Durable Power of Attorney for Finances? **Yes** **No**  
 Is this the same person as your DPOA for Health Care? **Yes** **No**  
 If no, fill in information below.

Name of DPOA for Finances: _____	
Address: _____ _____ City, ST, Zip	<div style="border: 1px solid black; padding: 5px;"> <p>Please attach a signed copy of the document</p> </div>
Phone: _____	Cell: _____

Do you have a Living Will or Advance Directives? **Yes** **No**

Do you have any religious preferences? **Yes** **No**  
 Please list: \_\_\_\_\_

Have you made arrangements for your funeral and/or burial? **Yes** **No**  
 In case of death I desire to be: **Buried** **Cremated**

Name of Funeral Home: _____	
Address: _____ _____ City, St., Zip	<div style="border: 1px solid black; padding: 5px;"> <p>Please attach a copy of your pre-paid funeral agreement</p> </div>
Phone: _____	

**Amount of prepaid funeral expenses: \$** \_\_\_\_\_

**Is this account irrevocable?** **Yes** **No**

Name of crematory/cemetery: _____	
Address: _____ _____ City, ST, Zip	
Phone: _____	

<b>Lot:</b> _____	<b>Block:</b> _____	<b>Section:</b> _____
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## In case of emergency please notify:

Emergency Contact Name (Primary):	Relationship:
Address: _____	
_____	
City, ST, Zip	
Phone: _____	Cell: _____
Email: _____	

Emergency Contact Name (Secondary):	Relationship:
Address: _____	
_____	
City, ST, Zip	
Phone: _____	Cell: _____
Email: _____	

Emergency Contact Name (Other):	Relationship:
Address: _____	
_____	
City, ST, Zip	
Phone: _____	Cell: _____
Email: _____	

## Level of Services Desired

Masonic Village Estates	Michigan Masonic Home	Jack F. Sander Health Care Center	Short-Term Rehab Unit

# Financial Worksheet

## IMPORTANT NOTE:

Please attach current documentation (copy of bank statements, copy of checks, Social Security annual statements, financial statements, pre-paid funeral agreement, etc.) for each area marked.

List monthly income from all sources:

Social Security	Pensions	Interest Income	Dividends	Annuity Income	Rental Income	List Any Other Income

Please list the estimated net value of your personal assets and how they are titled in each area listed below:

Account	Current Amounts	How is it Titled?
Checking or Money Market		
Savings and/or CDs		
Autos and/or RVs (copy of title needed)		
Home (copy of tax statement w/ SEV)		
Other Real Estate (copy of tax statement w/ SEV)		
Land Contract		
Stocks/Bonds		
Other Investments (provide detail)		
Trusts		
Life Insurance Cash Surrender Value		
Prepaid Funeral Irrevocable? Yes No		

**List monthly expenses for the following:**

Mortgage	Property Taxes	Home Insurance	Notes (loans) Payable	Credit Card Debt	Other

In the past five (5) years immediately preceding the date of this application, have you made a gift, otherwise transferred your interest in any assets to any persons at less than fair market value, or have you had a judgment entered against your assets?

**Yes**

**No**

**If yes,** please write a description of each asset, its value, the date of transfer, recipient, and the recipient's relationship to you. **Documentation is required.**

**Asset Description:** \_\_\_\_\_

**Value:** \_\_\_\_\_

**Date of Transfer:** \_\_\_\_\_

**Recipient:** \_\_\_\_\_

**Recipient's Relationship to you:** \_\_\_\_\_

**Additional Information:**

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Name of person to contact regarding status of this application: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to resident: \_\_\_\_\_

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Name of person completing this application if other than resident: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to resident: \_\_\_\_\_

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I hereby declare that all of the foregoing statements are complete and correct to the best of my knowledge. Masonic Pathways is authorized to verify any information, financial or otherwise, provided in this application.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

**Office Use Only**

\_\_\_\_\_ Residency approved by Finance Department. Date: \_\_\_\_\_

\_\_\_\_\_ Applicant will need to apply for Masonic Assistance Program.

\_\_\_\_\_ Applicant does not meet financial criteria.

\_\_\_\_\_ Other (explain):

## TO BE COMPLETED BY PHYSICIAN

*This information must be completed within 90 days prior to admission to Masonic Pathways. **Results from a chest x-ray taken within 12 months prior to admission** to the Masonic Home's for Residential, Assisted Living or Dementia Care services or within 90 days for admission to the J. F. Sanders Health Care Center must be submitted before admission can be approved.*

**Applicant's Name** \_\_\_\_\_

**Gender** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

### MEDICATIONS/TREATMENT:

Name	Dose	Freq.	Route	Diagnosis
1) _____				
2) _____				
3) _____				
4) _____				
5) _____				
6) _____				
7) _____				
8) _____				
9) _____				
10) _____				
11) _____				
12) _____				
13) _____				
14) _____				

If more space is needed, please attach second sheet.

(See Back Side)

Does the applicant use tobacco? YES NO If yes, amount and frequency \_\_\_\_\_

Does the applicant use alcohol? YES NO If yes, amount and frequency \_\_\_\_\_

Please list any known allergies:

NONE 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

Pneumococcal Vaccine? YES NO If yes, give date \_\_\_\_\_

PPD Status: POS NEG Unknown Date of last PPD \_\_\_\_\_

Vision: OD \_\_\_\_\_ OS \_\_\_\_\_ Please include copies of recent ophthalmology reports and lens prescriptions.

Hearing: Adequate Not Adequate Hearing Aids? None Single Bilateral Type: AD AS AU

Please include copies of recent audiograms, audiology, or ENT reports.

<b>Cognitive:</b>	<b>Memory</b>	Excellent	Good	Fair	Poor	
	<b>Orientation</b>	Excellent	Good	Fair	Poor	
	<b>Judgement</b>	Excellent	Good	Fair	Poor	<b>MMSE Score</b> _____

If cognitive impairments exist, please include copies of laboratory, imaging, and psychometric testing and consultations.

**Current or Past Psychiatric Diagnoses:**

None Known Anxiety Depression Psychosis Other \_\_\_\_\_

**Any known psychiatric hospitalizations or formal outpatient psychiatric care?** YES NO

If yes please include dates and providers.

<b>Functional Status:</b>	<b>Eating</b>	Independent	Assisted	Dependent		
	<b>Toileting (Bladder)</b>	Independent	Assisted	Dependent		
	<b>Toileting (Bowel)</b>	Independent	Assisted	Dependent		
	<b>Bathing</b>	Independent	Assisted	Dependent		
	<b>Dressing</b>	Independent	Assisted	Dependent		
	<b>Transferring</b>	Independent	Assisted	Dependent		
	<b>Ambulation</b>	Independent	Assisted	Dependent		
	<b>Assistive Devices</b>	None	Walker	Cane	Wheelchair	Electric Cart

**Any expected improvement in functional status?** YES NO

If yes, please explain: \_\_\_\_\_

In order to prevent any delays in the processing of your patient's application, please promptly fax this form to:

Masonic Pathways  
Residential Assisted Living and Village Estates  
Fax No. 989-466-3019  
J.F. Sanders Health Care Center and STR  
Fax No. 989-466-4438  
Questions? Call 989-466-3849 or 989-466-3818

Physician's Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_

# Medical Records Request List

In order to provide the highest quality of medical care, it is important that the medical staff at the Michigan Masonic Pathways has access to your previous health care records. Please complete this form and return it to the Admissions Office, along with a signed Medical Records Release Form for each provider listed, as soon as possible. With your prompt cooperation, our staff will make every effort to obtain your health care records prior to your arrival.

Your Name : \_\_\_\_\_

Primary Physician: Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone (    ) \_\_\_\_\_

Dentist: Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone (    ) \_\_\_\_\_

Optometrist: Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone (    ) \_\_\_\_\_

Specialist: Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone (    ) \_\_\_\_\_  
Treated for \_\_\_\_\_

Specialist: Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone (    ) \_\_\_\_\_  
Treated for \_\_\_\_\_

Hospital: Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone (    ) \_\_\_\_\_  
Treated for \_\_\_\_\_  
Hospital stay in past year? \_\_\_ Yes \_\_\_ No  
If yes, give dates \_\_\_\_\_

OVER



**TO BE COMPLETED BY LODGE OR CHAPTER SECRETARY**

**Affiliation Certification**

*The person listed below is in the process of applying for residency at Masonic Pathways. Please confirm the applicant's affiliation with your lodge or chapter, complete the remainder of this form, and return it to:*

Masonic Pathways  
Admissions Department  
1200 Wright Ave.  
Alma, MI 48801

**Applicant's Name** \_\_\_\_\_

**According to the Michigan Masonic Blue Book, the applicant is considered affiliated by virtue of one or more of the following qualifications:**

(Check all that apply)

- The applicant is a Master Mason who has been in continuous good standing in a Michigan Lodge for at least ten (10) years prior to the filing of the application.
- The applicant is the wife or mother of such a Master Mason.
- The applicant is a female member of the Order of the Eastern Star and her membership in a Michigan Chapter of the Order of the Eastern Star has continued in good standing for at least ten (10) years prior to the filing of the application.

**Applicant affiliated through membership of:**

Brother: \_\_\_\_\_ Date of Raising: \_\_\_\_\_

or

Sister: \_\_\_\_\_ Date of Raising: \_\_\_\_\_

- The applicant is not affiliated with this Lodge/Chapter.

Lodge/Chapter Name and Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Lodge or Chapter Secretary

\_\_\_\_\_  
Date