

**Saint Elizabeth Court**  
**Assisted Living Residence**  
**109 Melrose Street**  
**Providence, RI 02907**  
[mconnelly@stelizabethcommunity.com](mailto:mconnelly@stelizabethcommunity.com)  
**401-490-4646**

**Application for Residency**

**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 \_\_\_\_\_

**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:**

Ethnicity - White \_\_\_\_\_ African American \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian \_\_\_\_\_ other \_\_\_\_\_

**Saint Elizabeth Court**

**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:

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

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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 Value\$ \_\_\_\_\_

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 myself or Saint Elizabeth Court until a Residency Agreement has been signed by all parties involved.**

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**Signature of Applicant**

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