LOTT
RESIDENCE

Lott Assisted Living Residence
1261 Fifth Avenue
New York, NY 10029
T. 212.534.6464
F. 212.534.1184

Dear Admissions Candidate:

Thank you for your interest in Lott Assisted Living Residence. As a licensed assisted living program (ALP), Lott Residence provides a safe environment for residents age 65 or older who require assistance with the activities of daily living (i.e. bathing, dressing, toileting, etc.) but wish to maintain their independence.

Enclosed is the admission package. In order to process your application the following forms must be submitted:

- ☐ Application for Admission
- ☐ Medical Evaluation, completed by your doctor
- ☐ Mental Health Evaluation, completed by your doctor
- ☐ PPD Report, completed by your doctor
- ☐ Financial Questionnaire with documents (see Admissions Check List)

Your doctor must complete every section of the Medical Evaluation form and provide a clear description of the assistance you will need with activities of daily living, such as eating, transferring, toileting, dressing, grooming, housekeeping, incontinence care and medication management. Your doctor must print his/her name, address, and telephone number on the medical evaluation form.

A completed Financial Questionnaire with supporting financial documents must also be submitted. After your completed application has been submitted, the Admissions Coordinator will schedule an interview with the Admissions Committee.

Please submit the required documents to Dorothy Nelson, Admissions Coordinator, at the above address. She also can be contacted at Dorothy.Nelson@lottresidence.org or 212 534 6464, ext. 5153, if you require additional information.

Yours truly,

Nicole F. Atanasio, MS, RN-BC
President and CEO

Enclosure(s)

LOTT ASSISTED LIVING RESIDENCE

1261 Fifth Avenue
New York, NY 10029

Application for Admission

Please fill out entire application completely in order to be considered for admission

Date: _____

Applicant Name _____ Social Security #: _____

☐ Male ☐ Female Age: _____ Date of Birth: _____

Referred by: _____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single (never married)

Children: _____

Current Residence: _____ Phone: _____

_____

Own Home ☐ Hospital ☐ Nursing Home ☐ Other: _____

Nursing Home _____ Date of Admission: _____

Are you currently receiving home health services? ☐ Yes ☐ No
If yes: ☐ Visiting Nurse ☐ Private Hired Help ☐ PCA/HHA

How many hours/days/week? _____ How long? _____

What services are provided? _____

Most Recent Hospitalization/Rehab? _____ Where? _____

Reason: _____

Primary Contacts/Support Persons:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Phone: Home: _____ Phone: Home: _____

Work: _____

Cell: _____

Work: _____

Cell: _____

Attending Physician:

Name: _____

Address: _____

_____

Phone: _____

Other Health Care Providers:

Name: _____

Specialty: _____

Address: _____

Health Insurance:

Medicaid No.: _____

Medicare No.: _____

Prescription Drug Plan/Medicare Part D Plan Name:

_____

Prescription Drug Plan/Medicare Part D Number:

_____

HMO Plan Name: _____

Hospital of Choice: _____

Mental Health: _____

_____

Psychiatric hospitalizations? _____ Where? _____ Date: _____

Please explain: _____

_____

_____

_____

Personal Background

Wishes to be addressed as: _____

Where were you born/raised/lived most of your life?

_____

Highest Grade Completed: _____ Occupation: _____

Religious Affiliation (if any): _____ Place of Worship: _____

Have you ever been a client of Adult Protective Services? ☐ Yes ☐ No

If yes, when? _____

Health Care Proxy: ☐ Yes ☐ No Name: _____

Power of Attorney: ☐ Yes ☐ No Name: _____

DNR: ☐ Yes ☐ No Living Will: ☐ Yes ☐ No

Burial Instructions: _____

Can Applicant speak, read, and/or write in English: ☐ Yes ☐ No

If no, indicate primary language: _____

Daily Habits

How often do you drink alcohol? _____ How often do you smoke tobacco? _____

Preferred wake-up time: _____ Preferred bedtime: _____

Eating Habits

Do you have any dietary restrictions? _____

Food Allergies (List all): _____

Food preferences: _____

Food dislikes: _____

Daily Events: (check all that apply)

☐ Goes out _____ days a week

☐ Spends most time alone

☐ Spends most time watching TV

☐ Prefers small group activities

☐ Prefers large group activities

☐ Stays busy with hobbies; reading, fixed daily routine

☐ Contact with relatives/close friends ____ days per week

☐ Usually attends church, synagogue, etc.

Name and Location of House of Worship:

_____

Comments: _____

CONTINENCE STATUS/MANAGEMENT

Is the resident continent of urinary function? Yes ☐ No ☐
Is the resident continent of bowel function? Yes ☐ No ☐

IF ANSWER IS "NO" TO EITHER QUESTION, COMPLETE THIS SECTION, AS APPROPRIATE.

Urinary Incontinence	Bowel Incontinence
Less than once a week ☐ Several times a week ☐ Daily ☐ Day Only ☐ Night only ☐ Day and night ☐	Less than once a week ☐ Several times a week ☐ Daily ☐ Day Only ☐ Night only ☐ Day and night ☐
Current management techniques	**Current management techniques**

Prompting/reminding defers incontinence ☐ Timed voiding defers incontinence ☐ Uses incontinence pads/adult diapers: Day only ☐ Night only ☐ Day and night ☐ Catheter (specify type) _____ Comments: _____ _____ _____ Self-manage continence? Yes ☐ No ☐	Uses incontinence pads/adult diapers: Day only ☐ Night only ☐ Day and night ☐ Comments: _____ _____ _____ Self-manage continence? Yes ☐ No ☐

PHYSICAL FUNCTION

TASK	LEVEL OF ASSISTANCE	COMMENTS
Eating: (Ability to feel self meals and snacks)	☐ **Independent:** Able to feed self independently with or without assistive device ☐ **Intermittent Assistance:** Requires minimal, intermittent supervision and/or assistance ☐ **Continual Assistance:** Requires constant assistance and/or supervision throughout meal	**Dentures:** Upper Yes ☐ No ☐ Lower Yes ☐ No ☐ **Chewing difficulties:** Yes ☐ No ☐ **Difficulty Swallowing** Yes ☐ No ☐ **Modified consistency** Yes ☐ No ☐ Specify: _____
Ambulation: (Ability to safely walk and move about once in a standing position)	☐ **Independent:** Walks and climbs and descends stairs independently with or without assistive device. ☐ **Intermittent Assistance:** Walks and climbs and descends stairs with minimal, intermittent assistance and/or supervision **Prospective residents who require constant supervision or are dependent on a wheelchair are not appropriate candidates for Assisted Living.**	☐ Walker ☐ Quad Cane ☐ Cane ☐ Other: _____ **Falls within the last 3 months?** Yes ☐ No ☐ Frequency #: _____ Injury: _____ **Comments:**
Transferring: (Moving from bed to chair, on/off toilet, in/out of shower or tub)	☐ **Independent:** Able to transfer independently with or without assistive device ☐ **Intermittent Assistance:** Transfers with minimal human assistance and/or supervision ☐ **Continual Assistance:** Unable to transfer but can bear weight and pivot when transferred by at least one other person	**Comments:**

Toileting: (Getting to/from and on/off the toilet, cleansing self after elimination and adjusting clothing)	☐ **Independent:** Able to toilet independently with or without assistive device ☐ **Intermittent Assistance:** Able to toilet with minimal intermittent assistance and/or supervision ☐ **Continual Assistance:** Able to toilet with constant assistance and/or supervision	**Ostomy:** Yes ☐ No ☐ **Comments:**
TASK	**LEVEL OF ASSISTANCE**	**COMMENTS**
Bathing: (Getting in and out of tub or shower, washing and drying entire body)	☐ **Independent:** Able to bathe or shower independently with or without assistive device ☐ **Intermittent Assistance:** Able to bathe or shower with minimal intermittent assistance and/or supervision ☐ **Continual Assistance:** Able to bathe or shower with constant assistance and/or supervision	**Comments:**
Dressing: (Getting clothes from closets and drawers, dressing and undressing, upper/lower body, including buttons, snaps, zippers, socks and shoes)	☐ **Independent:** Able to dress and undress independently with or without assistive device ☐ **Intermittent Assistance:** Able to dress and undress with minimal, intermittent assistance and/or supervision ☐ **Continual Assistance:** Requires assistance throughout the dressing and undressing process ☐ **Total Assistance:** Requires another person to dress and undress upper and lower body	**Comments:**
Grooming: (Washing face, hair care, shaving, teeth/denture, fingernail care, eyeglasses care)	☐ **Independent:** Able to groom self independently with or without assistive device ☐ **Intermittent Assistance:** Requires grooming utensils to be set up and placed within reach ☐ **Continual Assistance:** Requires assistance throughout the grooming process ☐ **Total Assistance:** Depends entirely upon someone else for grooming	**Comments:**
Transportation: (Physical and mental ability to safely use a car, taxi, or public transportation [bus, train subway])	☐ **Independent:** Able to independently drive a regular or adapted car; OR uses a regular or handicap accessible public bus, train or subway ☐ **Independent:** But requests facility perform task ☐ **Intermittent Assistance:** Able to ride in a car only when driven by another person; AND/OR due to physical, cognitive or mental limitations occasionally requires another person to accompany him/her when using a bus, train or subway	**Comments:**

	☐ **Continual Assistance:** Able to ride in a car only when driven by another person; OR able to use a bus or handicap van, train or subway only when assisted or accompanied by another person ☐ **Total Assistance:** Unable to ride in a car, taxi, bus or van, and requires transportation by ambulance	
TASK	**LEVEL OF ASSISTANCE**	**COMMENTS**
Laundry: (Ability to do own laundry – to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand)	☐ **Independent:** Able to independently take care of all laundry tasks ☐ **Independent:** But requests facility perform task ☐ **Intermittent Assistance:** Able to do only light laundry, such as minor hand wash or light washer loads. Needs assistance with heavy laundry, such as carrying large loads of laundry ☐ **Continual Assistance:** Due to physical, cognitive or mental limitations, needs continual supervision and assistance to do any laundry ☐ **Total Assistance:** Unable to do any laundry	**Comments:**
Housekeeping: (Ability to safely and effectively perform light housekeeping and heavier cleaning tasks)	☐ **Independent:** Able to independently perform all housekeeping tasks ☐ **Independent:** But requests facility perform task ☐ **Intermittent Assistance:** Able to perform only light housekeeping (e/g/, dusting, wiping kitchen counters) tasks independently; AND/OR able to perform housekeeping tasks with intermittent assistance or supervision from another person ☐ **Continual Assistance:** Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process ☐ **Total Assistance:** Unable to effectively participate in any housekeeping tasks	**Comments:**
Shopping: (Ability to plan form, select and purchase items in a store and to carry them home or arrange delivery)	☐ **Independent:** Able to plan for shopping needs and independently perform shopping tasks, including carrying packages ☐ **Independent:** But requests facility perform task ☐ **Intermittent Assistance:** Able to do only light shopping and carry small packages, but needs someone to do occasional major shopping ☐ **Continual Assistance:** Unable to go shopping alone, but can go with someone to assist; OR unable to go shopping but is able to identify items	**Comments:**

	needed, place orders, and arrange for home delivery	

Why does applicant require assisted living at this time? _____

_____

_____

Applicant's statement of own needs, desires, fears, expectations, etc.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Applicant Signature Date

_____ _____ _____

Application Completed by: Relationship to Applicant Date

DSS-4449C (Rev. 4/97, 05/13, 9/13)

ALP MEDICAL EVALUATION

Check all that apply: ❑ AH ❑ EHP ❑ ALP ❑ Initial ❑ Rug Category Change ❑ 12 month ❑ Other

❑ **UAS-NY Summary Report is attached for RUG Category Change, 12 month and other assessments**

This form may be used to verify that an individual's health/safety needs can appropriately be met in an adult home, enriched housing program or residence for adults. It may also be used to verify that an applicant/resident of an Assisted Living Program (ALP) is medically eligible to reside in a nursing facility but does not require continual nursing or skilled care and the individual's needs can be met in an ALP.

Resident/Patient Name: _____ Date of Birth: _____

Facility Name: _____ Address: _____

_____

Sex: Male ❑ Female ❑ **Weight:** _____ **Blood Pressure:** _____

Primary Diagnosis/Prognosis:

Secondary Diagnoses/Prognosis:

Significant medical history & current conditions:	**Continence:** Bladder: ❑ Yes ❑ No Bowel: ❑ Yes ❑ No	**Allergies: KNA** ❑
Needs assistance with self-administration of medications? ❑Yes ❑No	**Type of Diet:** Regular ❑ NSA ❑ NCS ❑ Other: (Explain) ❑	

List all current medications (prescription and OTC, including dosage, type, frequency and method of administration and note special instructions: (attach additional sheets if necessary signed and dated by Physician)

MEDICATION	DOSAGE	TYPE	FREQUENCY	METHOD

Resident/Patient Name: _____

Is the individual free of communicable disease? ❑Yes ❑No If no, describe: _____

Does the individual require supervision and/or assistance by aide with:

bathing: ❑No If yes, is it?: intermittent: ❑ constant ❑

grooming: ❑No If yes, is it?: intermittent: ❑ constant ❑

dressing: ❑No If yes, is it?: intermittent: ❑ constant ❑

eating: ❑No If yes, is it?: intermittent: ❑ constant ❑

transferring: ❑No If yes, is it?: intermittent: ❑ constant ❑

ambulation: ❑No If yes, is it?: intermittent: ❑ constant ❑

toileting: ❑No If yes, is it?: intermittent: ❑ constant ❑ *Such that it requires toileting program 24 hours/7 days per week to maintain continence?

Describe any additional activity restrictions/needs: _____

Describe Current Treatment Plan (e.g., nursing, therapies, etc.): _____

Is Palliative Care appropriate/recommended?: ❑Yes ❑ No If yes, describe services: _____

Is the individual's condition stable? ❑Yes ❑No If no, describe: _____

Cognitive Impairment/Memory Loss (including dementia)

Does the individual have/show signs of dementia or other cognitive impairment? ❑Yes ❑No If yes, describe: _____

If yes, do you recommend testing be performed? ❑Yes ❑No If yes, describe: _____

If testing has already been performed, date/place of testing if known: _____

Mental Health Assessment (non-dementia)

Does the individual have a history, current condition or recent hospitalization for mental disability?

❑Yes ❑No If yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral? ❑Yes ❑No _____

Date of Today's Examination _____ **Recommended frequency of Medical Exams** _____

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared for in an Adult Home, Enriched Housing Program or an ALP.

_____

Physician Signature (required) Date

_____

Nurse Practitioner, Physician or Specialist's Assistant Signature Date

MENTAL HEALTH EXAMINATION

Name of Resident:

_____

The above named resident does not evidence need for placement in a residential treatment facility licensed or operated pursuant to article 19, 23, 29, or 31 for the mental health hygiene law.

1. I have examined _____ on _____

2. The above resident is mentally suited for care in an Enriched Housing Program Yes ☐ No ☐

3. Is this resident a danger to him/herself or others? Yes ☐ No ☐

4. Please list any psychiatric medications prescribes to the above names resident at this time. Please include dosage.

_____
_____
_____
_____
_____

5. Please list all significant mental health issues or present conditions, including diagnosis, which should be considered by the Enriched Housing Program in order to provide adequate service to the resident.

_____
_____
_____
_____
_____

Physician Stamp Here:

PHYSICIAN'S SIGNATURE	DATE
PHYSICIAN LICENSE #	
PRINT PHYSICIAN NAME	
PHONE NUMBER	
ADDRESS	

LOTT ASSISTED LIVING RESIDENCE
1261 FIFTH AVENUE
NEW YORK, NY 10029
TEL: (212) 534-6464

Resident Name: ______________________ **Apt:** __________

MD Name: ______________________

Initial PPD
Date: Brand:
If Positive, Chest x-ray date: mm.
Any other evaluation or treatment

Annual PPD Test
Date: Brand:
Date Read: Results : mm.
If Positive, Chest x-ray date:

Annual PPD Test
Date: Brand:
Date Read: Results : mm.
If Positive, Chest x-ray date:

Annual PPD Test
Date: Brand:
Date Read: Results : mm.
If Positive, Chest x-ray date:

Annual PPD Test
Date: Brand:
Date Read: Results : mm.
If Positive, Chest x-ray date:

Influenza Vaccine Date:
Influenza Vaccine Date:
Influenza Vaccine Date:

Pneumovax Date:

Booster PPD test:
Date: Brand:
Date: Read: mm.
Results:

Annual PPD Test
Date: Brand:
Date Read: Results : mm.
Results:

Annual PPD Test
Date: Brand:
Date Read: Results : mm.
Results:

Annual PPD Test
Date: Brand:
Date Read: Results : mm.
Results:

Annual PPD Test
Date: Brand:
Date Read: Results : mm.
Results:

Influenza Vaccine Date:
Influenza Vaccine Date:
Influenza Vaccine Date:

Others:
Date:
Date:
Date:

Comments:

LOTT ASSISTED LIVING RESIDENCE

1261 Fifth Avenue, New York, NY 10029 Telephone: 212 534 6464

Due to the nature of our facility, we can accept only the following diet orders for residents.

1) REGULAR
   No restrictions

2) NO CONCENTRATED SWEETS
   Diabetic: We cannot accept a calorie restricted dies such as: 1600, 1800 ADA

3) REDUCED FAT AND CHOLESTEROL
   We cannot accept low fat/low cholesterol

4) NO ADDED SALT
   We cannot accept a lower sodium restriction such as: 2 or 3 gm sodium

(No RENAL, SOFT, or other restrictive diets)

261 Fifth Avenue
New York, NY 10029
: (212) 534-6464
: (212) 534-1184

Lott Residence Financial Questionnaire

Please answer all questions and attach the required documents.

Name:	**Address:**
Telephone:	**Marital Status: (Circle one):** **Married - Widowed - Single, never married** **Legally Separated - Other-Explain**
Monthly Income:	**Resources - Give Current Month's Balance:**
☐ **Social Security**	☐ **Checking**
☐ **Pension (1):**	☐ **Statement Savings:**
☐ **Pension (2):**	☐ **Passbook Savings:**
☐ **SSI:**	☐ **Money Market**
☐ **Annuity:**	☐ **C.D.'s**
☐ **V.A. Pension**	☐ **Life Insurance:**
☐ **Public Assistance:**	☐ **Annuities, IRAs**
☐ **Other Income**	☐ **Trusts**
	☐ **Mutual Funds**
Health Insurance Premium:	☐ **Brokerage Accts.**
	☐ **Other:**
Contact: **Relationship:** _____ **Name:** _____	**Why do you want to live at Lott Residence?**
Address: _____ _____ **Home Tel:** _____ **Work Tel:** _____ **Cell Tel:** _____	
Date Completed:	**Date Received @ Lott Residence:**

LOTT ASSISTED LIVING RESIDENCE

1261 Fifth Avenue, New York, NY 10029 Telephone: 212 534 6464

MEDICAID REQUIREMENTS

Lott Assisted Living Residence is licensed by the NYS Department of Health as an Assisted Living Program (ALP). Medicaid reimbursement for residents entering ALP facilities requires Community based long-term care Medicaid or Institutional (Nursing Home) Medicaid.

Community Based Long-Term Medicaid

To obtain Community Based Long-Term Care through Medicaid the applicant must file an application for (a) Coverage with long-term care or (b) coverage for all covered care services at the local Human Resources Office (Telephone: 1-877-472-8411; see instruction sheet attached). The Long-Term Care Medicaid application requires documentation of the applicant's finances for the prior 36 month period. Once the applicant has obtained approval of the Community Based Long-Term Care Medicaid the following documents from the Human Resource Office must be submitted with the Lott Residence application.

1. MAP-2087 – Notice of Decision of your Medicaid Assistance Application
2. MAP-2060 – Budge Explanation or
3. MAP-2120B – Notice of Eligibility for Medicaid Assistance & Home Care Services

The following documents must also be submitted with the Lott Residence application for SSI purposes:

1. Birth Certificate
2. Social Security Card
3. Current Resources Information

Any client that is in a nursing home or has been a resident in a nursing home should already have Institutional Nursing Home Medicaid. The following documents obtained from the nursing home finance office must be submitted with the Lott Residence application:

1. MAP-2087 – Notice of Acceptance of Medicaid Assistance Application (Institutional Care/Nursing Home) Approval and Budget Letter
2. MPT-1124 – Discharge Notice
3. Birth Certificate, Social Security Card, & Current Resources Information will be required for Supplemental Security Income Application

If you require further information please call: Gail Johnson, Patient Accounts Manager
(212) 534-6464 ext. 5152

LOTT ASSISTED LIVING RESIDENCE

MEDICAID INFORMATION HELPLINE
(Available in several languages)
1-877-472-8411

To assist you with the Medicaid Application Process we have provided you with the above Medicaid information phone number. In addition, we have also given you a guide to follow to help your collection of documentation to be submitted with the Medicaid Application at your local Human Resources Administration.

A) Identity
State Issued Identification
Driver's License
U.S. Passport
Social Security Card

B) Marital Status
Marriage Certificate
Separation Agreement
Divorce Decree
Death Certificate

C) Residence
Landlord Statement
Current Rent Statement
Mortgage Records

D) Citizenship
Birth Certificate
Naturalization Certificate
U.S. Passport

E) Bank Accounts
Checking
Savings
IRA, etc
Current Statements & 3 months prior

F) Medical Expenses All receipts

G) Household All receipts

H) Income
SSA Benefits
SSD or SSI Benefits
Pension = Retirement or VA
Annuities

I) Proof of Life Insurance/Burial Assets/Burial Contracts

J) Proof of Home or Land Ownership

K) Proof of Health Insurance

L) Copy of Medicare Card

As a guide to assist with obtaining mandatory documents for Medicaid see the following:

Document	**Contact Agency**
Social Security Card	Social Security Administration www.socialsecurity.gov
Social Security Award Letter	www.socialsecurity.gov
State Issued Identification	Department of Motor Vehicles www.dmv.gov
Drivers' License	Department of Motor Vehicles www.dmv.gov
Birth Certificate Death Certificate	Department of Vital Statics (New York State) New York City www.nyc.gov/vitalrecords 125 Worth Street N.Y., N.Y. 10013
Marriage Certificate Divorce Decree	Department of Vital Statics (New York State) New York City: www.nyc.gov/vitalrecords
U.S. Passport	Department of Homeland Security www.dhs.gov

LOTT ASSISTED LIVING RESIDENCE

1261 Fifth Avenue, New York, NY 10029 Telephone: 212 534 6464

ADMISSIONS CHECKLIST

All Admission candidates must provide the Lott Residence with the following documents requested below. Please note that the application will not be processed unless all mandatory documents are attached upon receipt.

Identification of applicant:

☐ Application for Admission. Must be completely filled out

☐ Verification of Citizenship or permanent legal residence in the U.S.A. including a copy of **one** of the following: Birth Certificate, Naturalization Certificate, or current U.S. Passport.

Financial Information:

☐ **Copies of all current income including:** Social Security or active SSI benefits award letter, pension verification letters.

☐ **Birth Certificate or Active Passport.** ☐ **Life Insurance Policy**

☐ The most current month of banking and financial statements including checking, saving, money market, CDs, life insurance, and annuities ☐ **verification letters. Loyalties**

☐ Copies of current **Medicare, Medicaid, SS Card** health insurance, and/or prescription insurance cards

☐ **Verification letter of Loyalties** ☐ **Home ownership**

☐ Pool Trust Binder Joinder Agreement & Deposit Ledger

☐ Active State ID or Driver License.

☐ Copy of Divorce Decree/Marriage certificate/Death certificate.

☐ Budget/Approval letter from Medicaid.

☐ Nursing Home Budget/Approval letter

☐ **Resident who are on Medicaid a Check for $1,261.00 is due upon admission, for private pay a check in the amount of $6,000.00 and two months security deposit for $12,000.00 payable to Lott Residence.**

Medical Clearance:

☐ Form DSS-4449CC Medical Evaluation and Mental Health Evaluation to be completed by a physician, within 30 days of admission date.

☐ Mental health or psychiatric notes/evaluation from current physician.

☐ PPD form completed by a licensed physician within the last 30 days.

I have received this list and understand that these documents are required for admission to Lott Residence.

Applicant:_____ Date:_____

Applicant's Representative_____

Lott Residence at a Glance

☐ Private Studio Apartment and use of all Common Areas
☐ Restaurant-Style service of three (3) delicious, healthful meals a day
☐ All utilities (excluding phone and cable)
☐ 24-hour Emergency Response Security System
☐ Activities Center and Crafts Room
☐ Social, Educational, Recreational, Religious, and Cultural Programs
☐ Scheduled Transportation for Activities/Outings
☐ Maintenance of the Building Outdoor Area
☐ Library and Music Rooms
☐ Concierge Service
☐ Quality furnishings and Artwork throughout common areas
☐ Elegant Dining Room
☐ Private Dining available for Family/Guests
☐ Media/TV Lounge Room areas
☐ Wall-to-Wall carpeting
☐ Trash Removal
☐ Weekly linen and towel service
☐ Housekeeping
☐ Personal attention by designated Care Managers
☐ Physician on-premises
☐ Communication with resident's personal physician
☐ LPN assistance with medication management and other health related assistance
☐ Scheduling and reminding of medical appointments
☐ Fireproof Construction with sprinkler system throughout the Residence
☐ General Resident monitoring
☐ Exercise programs with Coaching