**The Oasis At Dodge Park**

101 Randolph Road

Worcester, MA01606

Telephone: (508) 853-8180

Fax: (508) 853-4545

**APPLICATION FOR ADMISSION**

(Please Type or Print Clearly)

Thank you for your interest in The Oasis At Dodge Park . In order to be considered for residency, please complete this application in full. The information requested will help us assess your ability to live in our Rest Home. Please do not hesitate to call us if you need assistance completing this form.

**I. General and Financial Information**

A.1 Applicant’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Telephone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sex: Male \_\_\_\_ Female \_\_\_\_

 Social Security No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If married please fill out section A.2.)

Former Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You A Veteran: [] Yes [] No (If yes – you may be qualified to VA assist)

Is Your Spouse A Veteran [] Yes [] No

If you have a deceased spouse, was he or she a veteran? [] Yes [] No

A.2 Your Spouse’s Name Work Phone:

 Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_

 Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work/Personal Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A.3 **Health Insurance**

|  |  |  |
| --- | --- | --- |
|   | Policy Name | Premium |
| Medicare |  |  |
| Medicare Advantage Plan (HMO) |  |  |
| Mass Health |  |  |
| Medigap (i.e. Medex) |  |  |
| Medicare Prescription Drug Plan |  |  |
| Dental Plan |  |  |
| Long Term Care\* |  |  |
| Others  |  |  |

* *If you have a long term care insurance policy, please provide us with a copy of the* policy

A.4. **Trust, Funeral and Vehicle**

 1. Are either you or your spouse the grantor or beneficiary of a trust? [] Yes [] NO

 *A “grantor” is the person who set up the trust. A “beneficiary” is someone who can receive money from the trust.*

 **If yes, please make the trust document available for review.**

2. Do you have a pre-paid funeral? [] Yes [] NO

 **If yes, please make the pre-paid funeral document available for review.**

3. Please list any vehicle you own including cars, vans, recreational vehicles, mobile home and boats:

|  |  |  |
| --- | --- | --- |
| Make/Year | Name Of Owner | Equity |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

A.5. Do either you or your spouse have a **life insurance** policy? If yes, please complete below. If there are more than three (3) policies, continue on a separate sheet.

 Policy # 1 Policy # 2 Policy # 3

|  |  |  |  |
| --- | --- | --- | --- |
| Owner Of Policy |  |  |  |
| Insurance Company |  |  |  |
| Face Value |  |  |  |
| Cash Surrender Value |  |  |  |
| Insured (Full Name) |  |  |  |
| Beneficiary (s) |  |  |  |
| Successor Beneficiary (s) |  |  |  |
| Other |  |  |  |

A.6. Please list any **retirement account you own, such as IRAs, 401(k), or 403(b) accounts, SEP plans**, etc.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  **Bank, Mutual Fund, etc** | **Account #** | **Owner** | **Beneficiary** | **Successor Beneficiary** | **Amount** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

A.7 Please list any **securities, stocks, bonds** other than retirement accounts (including US savings bonds), money market funds (in an investment house), etc? If investment is held by brokerage house, it is sufficient to list account and total value (not individual holdings)

|  |  |  |
| --- | --- | --- |
| **Name of Security** | **Name (s) In Which Security Is Held** | **Value** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

A.8. Please list each **bank account** other than retirement accounts (Including certificate of deposit, money market accounts, and checking accounts), owned by you or on which your name appears. For married couple we will need all accounts held by either you and/or your spouse.

|  |  |  |  |
| --- | --- | --- | --- |
| **Bank Name** | **Account #** | **Name(s) In Which Account IS Held** | **Amount** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

A.9 Have you made **gifts** of any money or property in the past 5 years? If so please list the date, value and to whom it was given.

|  |  |  |
| --- | --- | --- |
| **Date** | **Value of Gift** | **Person Receiving Gift** |
|  |  |  |
|  |  |  |

A.10 Please describe your **regular monthly income** (do not list income from investment) and, if applicable, your spouse income. If the income is directly deposit to a bank account, please indicate so. If you have more than one rental income, please provide the rental properties information as well on a separate sheet.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Income** | **Husband** | **Wife** | **Joint** | **Bank** |
| Salary,Wages |  |  |  |  |
| Social Security / SSI |  |  |  |  |
| Annuities |  |  |  |  |
| Pension |  |  |  |  |
| Trust |  |  |  |  |
| Rental (Net) |  |  |  |  |
| Business/Other |  |  |  |  |

Does someone other than you administer your finances? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A.11 **Real estate assets**

Does the Applicant own his/her home? Yes \_\_\_\_\_ No \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Mortgages and Liens – List Each Separately

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the property owned jointly? Yes \_\_\_\_\_ No \_\_\_\_\_

Name(s) of co-Owner(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Applicant own any additional property? Yes \_\_\_\_\_ No \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Mortgages and Liens – List Each Separately

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Creditor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Payment: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the property owned jointly? Yes \_\_\_\_\_ No \_\_\_\_\_\_

Name(s) of co-Owner(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was any real estate transfer to another entity (children, spouse, trust) in the past 60 months:

[] YES [] NO If yes Please specify:

Date of transfer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. Responsible Person and Childrens**

(Please Type or Print Clearly)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_ Zip: \_\_\_\_\_\_

Telephone (H): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone (W): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work E:mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Personal E:mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional E:mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a Health Care Proxy? \_\_\_\_\_\_\_\_\_\_\_\_ (If yes, please provide copy)

Is there a Power of Attorney? \_\_\_\_\_\_\_\_\_\_\_\_ (If yes, please provide copy)

Please provide us with information about your **children**. Please include **full legal names including middle initials**

|  |  |  |  |
| --- | --- | --- | --- |
| **Child # 1 Name** |  | Primary email address |  |
| Street Address |  | Child of this marriage? | [] Yes [] No |
| City/State/Zip |  | Adopted? | [] Yes [] No |
| Work Phone # |  | Disabled? | [] Yes [] No |
| Home Phone #  |  | POA? | [] Yes [] No |
| Cell Phone # |  | Health Care Advance Directive | [] Yes [] No |
| Fax # |  | Occupation |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Child # 2 Name** |  | Primary email address |  |
| Street Address |  | Child of this marriage? | [] Yes [] No |
| City/State/Zip |  | Adopted? | [] Yes [] No |
| Work Phone # |  | Disabled? | [] Yes [] No |
| Home Phone #  |  | POA? | [] Yes [] No |
| Cell Phone # |  | Health Care Advance Directive | [] Yes [] No |
| Fax # |  | Occupation | Fax # |

|  |  |  |  |
| --- | --- | --- | --- |
| **Child # 3 Name** |  | Primary email address |  |
| Street Address |  | Child of this marriage? | [] Yes [] No |
| City/State/Zip |  | Adopted? | [] Yes [] No |
| Work Phone # |  | Disabled? | [] Yes [] No |
| Home Phone #  |  | POA? | [] Yes [] No |
| Cell Phone # |  | Health Care Advance Directive | [] Yes [] No |
| Fax # |  | Occupation | Fax # |

**III. Medical Information/Preliminary Service Plan**

(Please Type or Print Clearly)

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will Physician attend here? Yes \_\_\_\_\_ No \_\_\_\_\_\_

Physician’s Hospital Affiliation (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your present state of health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a health condition that requires regular, daily attention or monitoring? (e.g. on oxygen, insulin dependent diabetes, blood pressure, skin condition) Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

If yes, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who monitors it now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you see a medical specialist? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on medication at the present time? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Please list medications including over the counter, vitamin, etc:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Direction** | **Prescribing Physician** | **Start Date** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Do you need assistance with medications? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Are you on a special diet? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much walking do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have difficulty with stairs? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Is incontinence a problem? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

If yes, how often? Occasionally \_\_\_\_\_ Regularly \_\_\_\_\_\_

How do you care for you incontinence? Independent \_\_\_\_\_ Need Assistance \_\_\_\_\_\_

It would be helpful to us in evaluating your needs to have you rate your skills in the following areas:

I = Independent M = Moderate Assist T = Total Assist

 Rating Comments

Bathing \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dressing \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walking \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Housekeeping \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laundry \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Budgeting \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shopping \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transportation \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fire Awareness \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IV. Mental Status/Behavior of Applicant**

(Please Type or Print Clearly)

|  |  |  |  |
| --- | --- | --- | --- |
| Alert \_\_\_\_\_ | Appropriate \_\_\_\_\_ | Cooperative \_\_\_\_\_ | Oriented \_\_\_\_\_ |
| Confused \_\_\_\_\_ | Wanders \_\_\_\_\_ | Combative \_\_\_\_\_ | Disoriented \_\_\_\_\_ |

I hereby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that if any information has been falsely represented or any material omissions made, such misrepresentation or omission would constitute sufficient cause for voiding my application for admission and may be a basis for liability for any unpaid charges to The Oasis At Dodge Park . All of the information will be kept confidential by The Oasis At Dodge Park .

I understand and agree that the foregoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until an Admission Agreement has been signed by the parties hereto.

Signature of Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

The Oasis At Dodge Park complies with the provisions of Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, and all agreements imposed pursuant thereto to the end that no person shall be eliminated from participation and/or denied benefits or otherwise be subject to discrimination on the basis of race, creed, color, national origin, disability, age, or veteran status in the provision of care or service for residents or in employment practices.