APPLICATION FOR RESIDENCY

(Please check all that apply)

Date ____/____/____

Western New York

- ☐ Elderwood Village at Bassett Park
- ☐ Elderwood Assisted Living at Cheektowaga
- ☐ Elderwood Assisted Living at Hamburg
- ☐ Elderwood Assisted Living at Tonawanda
- ☐ Elderwood Assisted Living at West Seneca
- ☐ Elderwood Assisted Living at Wheatfield
- ☐ Elderwood Village at Williamsville

Central/Northern New York

- ☐ Elderwood Village at Colonie
- ☐ Elderwood Village at Fairport
- ☐ Elderwood Village at Greece
- ☐ Elderwood Village at Ticonderoga
- ☐ Elderwood Village at Vestal
- ☐ Elderwood Assisted Living at Waverly

Name _____
Last First Middle

Address _____
Street City State Zip

Telephone _____ Date of Birth ___/___/___ Social Security # _____

Are you a Veteran: ❑ Yes ❑ No

Age _____ Gender _____ Citizenship _____ Spouse of Veteran: ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Divorced ❑ Widowed ❑ Married

Name of Spouse _____ Spouse SS# _____

Present Location of Applicant (if other than home address):

Address _____
Street City State Zip Code

Former Residence in an Adult Care Facility: ❑ Yes ❑ No

Name of Residence _____ Date _____

Number of Living Children _____ Former Occupation _____

Religion _____ Church _____

Designated Representatives:

Name	Address/Zip Code	Home Phone	Work/Cell Phone	Relationship

Power of Attorney/Guardian/Conservator:

Name_____Telephone_____

Address_____City_____State_____Zip_____

Responsible Party:

Name_____Email:_____Telephone_____

Address_____City_____State_____Zip_____

Health Care Providers

Type of Doctor	Name	Address	Telephone/Fax
In-house Physician			
Primary Physician			
Preferred Hospital			
Dentist			
Cardiologist			
Neurologist			
Orthopedic			
Surgeon			
Home Care Agency			
Other			

Advance Directives:

Do Not Resuscitate Order: ❑ Yes ❑ No Health Care Proxy: ❑ Yes ❑ No Living Will: ❑ Yes ❑ No
MOLST: ❑ Yes ❑ No Organ Donation: ❑ Yes ❑ No

Funeral Home _____

Health Insurance: Please attach copies of all insurance cards to application

Medicare No._____Part A_____Part B_____Effective Date___/___/___

Medicaid Case No._____CIN No._____County _____

Effective Date_____/_____/_____ Pending Application/Date Submitted_____/_____/_____

Health Ins. Co._____Policy No._____Group No._____

Other Health Ins. Co._____Policy No._____Group No._____

Prescription Insurance Co._____Policy No._____

Pharmacy to be used at our residence:

❑ In-house Pharmacy ❑ Other (Include Name/Address/Phone#) _____

_____

_____

Financial Information: **Please attach current bank/financial statements for all information listed**

Monthly Income		**Monthly Expenses**	
Social Security	$	Car Insurance	$
Retirement Pension	$	Health Insurance	$
Veteran's Pension	$	Prescriptions	$
Dividends	$	Physician Co-pays	$
Interest	$	Mortgage Payment	$
IRA/TDA/TSA	$	Outstanding Loans	$
Trust Funds	$	Long Term Care Insurance	$
Disability	$	Other Liabilities	$
Total Monthly Income	**$**	**Total Monthly Expenses**	**$**

BANK ACCOUNTS

Checking Accounts:

Bank _____ Account #_____ Balance $_____

Bank _____ Account #_____ Balance $_____

Savings Accounts:

Bank _____ Account #_____ Balance $_____

Bank _____ Account #_____ Balance $_____

Bank _____ Account #_____ Balance $_____

Other Bank Accounts (cash deposits):

Bank _____ Account #_____ Balance $_____

Bank _____ Account #_____ Balance $_____

Bank _____ Account #_____ Balance $_____

Bank _____ Account #_____ Balance $_____

Stock/Stock Funds/Bonds/Money Markets:

Name/Address _____Value_____

Name/Address _____Value_____

Name/Address _____Value_____

Name/Address _____Value_____

Name/Address _____Value_____

Annuities:

Name/Address _____Value_____

Name/Address _____Value_____

Life Insurance Policies:

Name/Address _____ Face Value_____

Real Estate:

Address_____ Assessed Value_____

Trusts:

Name/Address _____ Date Established ____/____/____

Burial Account: ❑ Yes ❑ No

Third Party Responsibility: If any other person will be responsible for paying a part or the entire monthly rent, responsible party must sign admission agreement.

To the best of my knowledge everything stated in this application is correct and accurate

_____ _____/_____/_____

Signature of Applicant or Responsible Party **(Required)** Date

_____ _____/_____/_____

Signature of Payee, if different from Applicant or Responsible Party Date

Applications are accepted and considered without regard to age, race, disability, health characteristics and care needs, income, ethnicity, religion, organizational member ship, sponsor, sex, sexual preferences, psychiatric diagnoses, or veterans; primarily persons age 65 and older are eligible for admission consideration as stated in Public Health Law.