**ASSISTED LIVING APPLICATION FOR RESIDENCY** *(Check all that apply)*

## 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

## Pennsylvania

- ☐ Elderwood Senior Living at Lancaster, PA

**Date** ____/____/____

**Accommodation Preferred:** ❑ **Private** ❑ **Semi-Private**

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_____

Number of Living Children _____ Former Occupation _____

Religion _____ Church _____

**Persons to be Notified in Case of Emergency:**

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

**Power of Attorney/Guardian/Conservator:**

Name _____ Telephone _____

Address _____City_____State_____Zip_____

**Person to Receive Monthly Invoice:**

Name_____ Telephone_____

Address_____ City_____State_____Zip_____

**Health Care Providers**

| Type of Doctor | Name | Address | Telephone/Fax |
|---|---|---|---|
| ❑ Inhouse 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

**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.**