APPLICATION FOR ADMISSION
(Please check all that apply)

Western New York
- ❑ Elderwood at Amherst
- ❑ Elderwood at Cheektowaga
- ❑ Elderwood at Grand Island
- ❑ Elderwood at Hamburg
- ❑ Elderwood at Lancaster
- ❑ Elderwood at Lockport
- ❑ Elderwood at Wheatfield
- ❑ Elderwood at Williamsville

Central/Northern New York
- ❑ Elderwood at Hornell
- ❑ Elderwood of Lakeside at Brockport
- ❑ Elderwood at Liverpool
- ❑ Elderwood at North Creek
- ❑ Elderwood at Ticonderoga
- ❑ Elderwood of Uihlein at Lake Placid
- ❑ Elderwood at Waverly

Date ____/____/____

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 a Nursing Home or Adult Care Facility: ❑ Yes ❑ No

Name of Residence ______________________________________ Dates _______________

Number of Living Children ____________ Former Occupation ______________________

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 ____

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________

Personal Physician: ________________________

Address ______________________________________ Telephone ______________

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.__________________

LTC Insurance Policy Name:________________ Policy # ________________________

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

Monthly Income

Social Security $ __________

Retirement Pension $ __________

Veteran's Pension $ __________

Dividends $ __________

Interest $ __________

IRA/TDA/TSA $ __________

Trust Funds $ __________

Disability $ __________

Railroad Pension $ __________

Supplementary Security Income $__________

Salary $ __________

Other Monthly Income $ __________

Monthly Expenses:

Health Insurance Premiums $ __________

Mortgage Payment $ __________

Outstanding Loans $ __________

Long Term Care Insurance $ __________

Other Liabilities $ __________

Credit Card $ __________

BANK ACCOUNTS

Name of Investment/Broker Accts ______________________________ Present Value __________

Address of Investment/Broker Accts ____

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_____________

How owned? ❑ Individually ❑ Joint Tenant (Name/Address of Other Tenant) ________________

❑ Trust (Name/Address of Trustee) ______________________________________

Applicant's Attorney ______________________________________ Phone ________________

Address ____

Trusts:

Name/Address ______________________________________ Date Established ____/____/____

Prepaid Burial Account: ❑ Yes ❑ No

Name/Address of Trusts ___________________________ Date Trust Established ________

Beneficiaries ____ Amount _______________

Other Assets ____

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.

Has there been a transfer of **any** asset within the past 5 years? ❑ Yes ❑ No

If yes, what was transferred? ____

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; persons under 16 years of age are not eligible for admission consideration as stated in Public Health Law.