

APPLICATION FOR RESIDENCY

Thank you for considering residency at Ingersoll Place! Your completed application is part of our admission process. Much of the information that we request is required by New York State agencies, including Department of Health.

Please contact an Ingersoll representative if you have any questions.

PERSONAL INFORMATION

Name _____
Last First MI

Present Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Sex: Male Female Marital Status: Single Widowed Married Divorced

Spouse's Name: _____ Address: _____

Have you served in the US Military? Yes No

Has your spouse served in the US Military? Yes No

Please Check One:

ETHNICITY

- No, Not of Hispanic, Latino/a or Spanish Origin
- Yes, Mexican, Mexican America, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Another Hispanic, Latino/a or Spanish Origin
- Prefer not to say

RACE

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Korean |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Samoan |
| | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Prefer not to say |

Anticipated Admission Information (Office Use Only—Do Not Fill out)

Completed by an Ingersoll Representative

Admission Date: ____/____/____ Rate: _____ Apartment Number: _____

HEALTH CARE INFORMATION—Providers (Physician, Cardiologist, Orthopedist, etc.)

PRIMARY CARE	Physician Name _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____
Office Phone Number: _____	Office Fax Number: _____
Emergency Contact Number: _____	

Physician Name _____	Specialty: _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____
Office Phone Number: _____	Office Fax Number: _____
Emergency Contact Number: _____	

Physician Name _____	Specialty: _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____
Office Phone Number: _____	Office Fax Number: _____
Emergency Contact Number: _____	

Other Health Care Providers

DENTIST	Name: _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____
Office Phone Number: _____	Office Fax Number: _____

If there are additional health care providers you wish to list, please include them on a separate page.

Hospital of Choice: _____

Address: _____

HEALTH INSURANCE (Please provide copies of both sides of each insurance card)

Medicare No. _____ Policy No. _____ Type: _____

Other Coverage: _____ Policy No. _____

Other Coverage: _____ Policy No. _____

HEALTH CARE CHOICES

Do you have the following documents? If so, please provide copies.

Health Care Proxy Yes No

Living Will Yes No

Do Not Resuscitate Order (DNR/ MOLST) Yes No

Interment Instructions: _____ Phone Number: _____

Address: _____

Durable Power of Attorney Yes No (If yes, please provide copies)

Name of Person: _____ Phone Number: _____

Address: _____

Power of Attorney Yes No (If yes, please provide copies)

Name of Person: _____ Phone Number: _____

BUSINESS CONTACTS

Attorney Name: _____ Phone Number: _____

Address: _____

Financial Contact Name: _____ Phone Number: _____

Address: _____

CONTACT INFORMATION

Emergency Contact

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Phone No. _____ Cell Phone No. _____

Home Phone No. _____ Work Phone No. _____

Email Address: _____

Alternate Contact

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Phone No. _____ Cell Phone No. _____

Home Phone No. _____ Work Phone No. _____

Email Address: _____

I understand that this application is only part of the admission process , and that an approved application alone does not guarantee residency. In order to be admitted to Ingersoll Place, I understand that I must meet the Admission Standards as specified in the New York State Department of Health regulations and must have a medical visit and completed medical evaluation form within thirty (30) days prior to my admission date. I am aware that Ingersoll representatives can assist me with the process.

My first month's rent in the amount of \$ _____ will be payable at the time of move-in if not before. If I move in to Ingersoll Place on a date other than the first of the month, my first month's rent will be prorated.

ALL OF THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE AND CORRECT

Applicant's Signature: _____ Date: _____

Responsible Party's Signature: _____ Date: _____

Ingersoll Representative Signature: _____ Date: _____

FINANCIAL DISCLOSURE

Each prospective resident is required to give a disclosure of financial resources and obligations. Ingersoll Management will hold all of the information given on this form in the strictest confidence. Please list your monthly income, assets and liabilities:

ASSETS AVAILABLE TO PAY FOR CARE	DOLLAR AMOUNT
Cash, Savings, Checking	\$
CD's, Money Market, etc.	\$
Stocks or Bonds	\$
IRA's, Annuities	\$
All Real Estate Holdings	\$
Life Insurance (cash value and face value)	\$
Trust Fund/ Estate (please provide a copy)	\$
Other (please list)	\$
Other (please list)	\$
Total Assets	\$
MONTHLY INCOME	DOLLAR AMOUNT
Social Security	\$
Pensions/ Retirement	\$
Dividends	\$
Insurance/ Annuity	\$
Real Estate or Rental Income	\$
Individual Retirement Account	\$
Family Contributions	\$
Trust	\$
Other (please list)	\$
Total Income	\$
LIABILITIES	DOLLAR AMOUNT
Balance Owed On Mortgage	\$
Notes Payable to Banks (Credit Cards, Loans, Car)	\$
Other Debts	\$
Total Liabilities	\$

- Are assets held jointly? Yes No If yes, with whom? _____
- Do you have Long Term Care Insurance? Yes No (If yes, please provide a copy of the declaration page of the policy showing what the policy will cover for care.)

(continued on next page)

I hereby certify that the information on this form is true to the best of my knowledge and belief and that I have not purposely withheld any information about my assets or income from Ingersoll Place.

Name of Prospective Resident: _____

Signature: _____ Date: _____

Name of Prospective Resident Representative: _____

Signature of Representative*: _____ Date: _____

Executive Director: _____ Date: _____

Caroline Thompson _____

*NOTE: If being completed by Power of Attorney, please sign and provide appropriate documentation

Please provide the following (most recent) documents for verification of amounts listed above:

- Bank Statements- to support receipt of Social Security, Pension, Investment Income
- Real Estate Deed- if equity in a house is available to help cover care costs
- Investment Portfolio Statements- to support held assets available to help cover care costs
- Other documents- to support held assets available to help cover care costs (ie: life insurance)
- Tax Return- Only needed if items listed above are not available- (1st page of 1040)