Ingersoll Place
ASSISTED LIVING

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

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

Completed by an Ingersoll Representative

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

Admitted From : ☐ Own Home ☐ Hospital ☐ SNF ☐ Other_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Discharge Date: _____/_____/_____

Admitted From : ☐ Own Home ☐ Hospital ☐ SNF ☐ Other_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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 then 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: _____

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FINANCIAL DISCLOSURE

Ingersoll Management will hold all of the information given on this form in the strictest confidence

ASSETS	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	$
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	$

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.

Signature of Resident: _____ Date: _____

Signature of Resident Representative: _____Date:_____

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

- 2 years Tax Returns
- Bank Statement
- Interest Statements
- Real Estate Deed
- Other