CHAMPLAIN VALLEY SENIOR COMMUNITY

APPLICATION FOR RESIDENCY

Thank you for considering residency at Champlain Valley Senior Community! Your completed application is part of our admission process. Much of the information that we request is required by New York State agencies, including the Department of Health. Please let us know if you have any questions when completing this form. We look forward to welcoming you to our community!

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 _____

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: _____/_____/_____ *Discharged To:* ☐ *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) ☐ *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:* _____

Address: _____

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 Champlain Valley Senior Community (CVSC) 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 CVSC 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, and any deposit that I may have previously paid will be credited towards this amount. If I move in to CVSC 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: _____

CVSC Representative Signature: _____ Date: _____