

Application for Residency and Financial Disclosure Form

Notice of Intent: The purpose of this form is to ensure applicants for residency meet the medical criteria for independent living and have adequate resources to cover the monthly rental fee, plus average personal expenses. This is not intended to be a full and complete disclosure of your financial standing. As such, you may not need to answer all questions to demonstrate financial eligibility. If concerns regarding financial or medical eligibility arise, you may be asked to furnish more detailed information.

Pledge of Confidentiality: We understand the sensitivity of the information required to base a decision of financial and medical eligibility for residency at Partridge Knoll. Please be assured all information you provide is used solely for the purpose of determining eligibility for residence and is kept in the strictest confidence. Should you decide not to pursue residency, any and all application materials containing your confidential information will be returned upon your request.

Instructions: Please fill in the blanks or check the appropriate responses. (If the question does not apply or does not require financial disclosure, please indicate N/A in the blank provided.) Please complete the entire application. Incomplete applications will cause delays in processing your request for residency.

Identifying Information:

Name: _____ Date of Birth: _____

Street Address: _____

City/State/Zip Code: _____

Telephone: _____ Social Security Number: _____

Preferred Title: [] Mr. [] Mrs. [] Miss [] Other: _____

Current Residence:

How long have you lived at your present address? _____

Do you own or rent your current home? Own Rent

What is the amount of your monthly rental or mortgage? _____

If you are a homeowner:

- Do you plan to sell your home before moving to Partridge Knoll? Yes No N/A
- Please indicate the appropriate range for the assessed value of your home:
 \$75,000 or less \$75 - \$100,000 \$100 - \$150,000
 \$150,000 or more

Financial Disclosure:

1. **Income:** Please indicate the appropriate range for your total annual income. (Sources of income include social security and pension benefits, as well as rental income, interests, etc.)

\$15 - \$20,000 \$20 - \$25,000 \$25 - \$30,000
 \$35 - \$45,000 \$45 - \$50,000 \$50,000 or more

2. **Assets:** Please indicate the appropriate range for the total value of your assets. (Assets include savings and investments, such as CD's, stocks, bonds, mutual funds, insurance, annuities, etc.)

\$10 - \$20,000 \$20 - \$30,000 \$30 - \$40,000
 \$40 - \$45,000 \$50 - \$75,000 \$75 - \$100,000
 \$100 - \$150,000 \$150 - \$200,000 \$200,000 or more

3. Real Estate:

Do you own property *in addition* to your current home? Yes No N/A

If yes, please indicate the appropriate range for the assessed value of your other real estate holdings:

\$50,000 or less \$50 - \$75,000 \$75 - \$100,000
 \$100 - \$150,000 \$150,000 or more

Financial Affairs:

Will you be handling your own affairs? Yes No

Have you established a financial Power of Attorney (POA) or Living Trust? Yes No

If yes, please provide the following information:

Name of Power of Attorney or Trust Administrator: _____

Address: _____

Telephone Number: _____ Relationship to Applicant: _____

If your monthly invoices should be sent to someone other than yourself, please provide the following identifying information for that individual:

Name: _____ Telephone Number: _____

Address: _____

Housing Preference:

The Saint Regis TheRaquette The St. Lawrence

The Valley TheSouthwood The Adirondack

Automobile:

Are you planning to maintain an automobile while a resident of Partridge Knoll? Yes No

Are you interested in renting garage space when available? Yes No

Pets:

Will you be bringing a pet with you to Partridge Knoll? Yes No

If yes, what kind of pet? _____

Health/Medical Information:

Primary Care Physician: _____ Telephone: _____

Full Address: _____

Describe your health condition: _____

Please list any allergies you may have: _____

Do you smoke? [] Yes [] No

Well Being Checks:

Do you wish to participate in the daily well-being check included in your service package?

[] Yes [] No

Emergency Contacts:

1. Name: _____ Telephone: _____

Address: _____

Relationship to Applicant: _____

2. Name: _____ Telephone: _____

Address: _____

Relationship to Applicant: _____

Applicant Signature:

I certify that the information contained in this application is true and correct to the best of my knowledge. I understand that any misrepresentation of the information contained in this application may disqualify me from residency at Partridge Knoll.

I am aware that Partridge Knoll *is not a health care facility*, and I am independent with respect to daily living. Furthermore, I recognize I may be asked to provide a medical doctor's written certificate regarding my ability to live independently after my application has been conditionally approved.

Signature

Date

Financial Disclosure Statement (Must be completed by each individual: joint holdings must be so noted)

Sources of *Current* monthly income (record actual amount)

	APPLICANT	SPOUSE
Social Security:	_____	_____
Veterans Pension:	_____	_____
Other Pension Number:	_____	_____
Dividends:	_____	_____
Interest:	_____	_____
IRA/TDA/TSA:	_____	_____
Other Income (list sources)	_____	_____
Total Monthly Income:	_____	_____

Sources of Cash Assets (record actual amount)

	APPLICANT	SPOUSE
Savings:	_____	_____
Checking:	_____	_____
CDs:	_____	_____
Maturity Date:	_____	_____
Stocks & Bonds:	_____	_____
IRA/Annuities:	_____	_____
Life Insurance:	_____	_____
Cash Value:	_____	_____
Total Cash Assets:	\$ _____	\$ _____