Application for Camillus Ridge Terrace

Camillus Ridge Terrace
An Assisted Living Community

2453 West Genesee Turnpike (Rte. 5)
Camillus, New York 13031

LEVEL OF CARE IN WHICH APPLICANT IS APPLYING FOR:
(please check one)

Adult Care _____ Memory Care Neighborhood _____

Name of applicant _____
Last First Middle Initial

Address: _____

Phone _____ County _____ Sex _____ Marital Status _____

Date of Birth _____ Age _____ Religion _____ SS# _____

Medicare Number _____ (A) _____ (B) _____ Medicaid Number _____

Veteran _____ yes _____ no Funeral Arrangements _____

Other Insurance Coverage *(please specify company and policy numbers)*:

1) _____

2) _____

Primary Physician _____

Address _____

Phone Number (s) _____

Primary Contact Person/Person to Contact in Case of Emergency

Name _____

Address _____

Relationship _____ Power of Attorney _____ Yes _____ No

Phone (H) _____ (W) _____

Secondary Contact Person(s)

Name _____

Address _____

Relationship _____ Power of Attorney _____ Yes _____ No

Phone (H) _____ (W) _____

Name _____

Address _____

Relationship _____ Power of Attorney _____ Yes _____ No

Phone (H) _____ (W) _____

CONFIDENTIAL FINANCIAL DISCLOSURE

Monthly Income: **Total Income**

Social Security _____

Supplemental Social Security _____

Interest Income _____

Dividend Income _____

Pension _____

Annuity _____

Support from relatives _____

Banking Assets: **Total Value**

Savings Accounts (bank names and account numbers):

_____ _____

_____ _____

Checking Accounts (bank names and account numbers):

_____ _____

_____ _____

Investments:

Certificates of Deposit (bank name):

_____ _____

_____ _____

Stocks/Bonds (name and number of shares):

_____ _____

_____ _____

Mutual Funds:

_____ _____

_____ _____

Life Insurance:

Paid Up Life Insurance Policies:

_____ _____

Revocable _____ Irrevocable _____

Real Estate:

Property Address:

_____ _____

_____ _____

Other Assets: **Total Value:**

_____ _____

_____ _____

The financial information on this form is a true and correct statement of my financial position to the best of my knowledge.

_____ or _____

Signature of Applicant Date Signature of Responsible Party Date

MEDICAL CONDITION

Does the applicant smoke? _____ Yes _____ No; if yes, how much?_____

Please check yes or no for the following questions:

Incontinent: _____yes _____ no

(bowel _____ bladder _____ or both _____)

Walks unassisted: _____yes _____ no

Uses walker: _____yes _____ no

Uses cane: _____yes _____ no

Uses wheelchair: _____yes _____ no

Dentures: _____yes _____ no

Glasses: _____yes _____ no

Does the applicant require assistance with any of the following needs?

Eating: _____yes _____ no

Dressing: _____yes _____ no

Bathing: _____yes _____ no

Special Diet: _____yes _____ no

(if yes, please specify diet: _____)

_____

Has the applicant exhibited the following behavior:

Memory Loss: _____yes _____ no

Confusion: _____yes _____ no

Verbal Disruption: _____yes _____ no

Physical Disruption: _____yes _____ no

Hallucination: _____yes _____ no

Delusions: _____yes _____ no

Depression: _____yes _____ no

Other: _____

_____

_____

_____