OSWEGO HEALTH | SPRINGSIDE AT SENECA HILL

Application for Residency

Springside at Seneca Hill
Premier Independent Senior Living
10 County Route 45A
Oswego, NY 13126

Phone: (315) 343-5658
Fax: (315) 207-0179

CONFIDENTIAL DOCUMENT

www.oswegohealth.org

SECTION I – PERSONAL INFORMATION

Applicant Name _____ Phone _____

*Co-Applicant Name _____

* If Co-Applicant must complete a separate application if other than Spouse

Address _____

City _____ State _____ Zip _____

Applicant's Date of Birth _____ Social Security No. _____

Co-Applicant's Date of Birth _____ Social Security No. _____

SECTION II - RESIDENCE

Do you own or rent your home? _____

How long at current address? _____

Mortgage Balance (if any) _____ - or - Current rental rate _____

If owner, do you plan to sell your home before moving to Springside? _____

If you have lived at your current address two years or less, list your previous addresses within the last 5 years, beginning with your current address:

ADDRESS	OWN/RENT & LANDLORD NAME	HOW LONG THERE
1.		
2.		
3.		
4.		

SECTION III – PERSONAL HISTORY

Marital Status: ☐ Married ☐ Single (never married) ☐ Widowed

☐ Divorced/Separated

Siblings (List all. Please continue list on a separate sheet of paper if more space is needed.)

NAME	ADDRESS	PHONE
1.		
2.		
3.		
4.		

Children (List all. Please continue list on a separate sheet of paper if more space is needed.)

NAME	ADDRESS	PHONE
1.		
2.		
3.		
4.		

Personal References (not related to you)

NAME	ADDRESS	PHONE
1.		
2.		
3.		
4.		

Work History (Last three employers)

COMPANY NAME	LOCATION	JOB/POSITION	HOW LONG EMPLOYED
1.			
2.			
3.			
4.			

SECTION IV – PERTAINING TO FINANCIAL INFORMATION

Will you need to draw upon your savings (assets) to meet expense? ☐ Yes ☐ No

Which payment option do you prefer? (Congregate Apts. Only) ☐ Equity ☐ Rental

Will you be handling your own financial affairs? ☐ Yes ☐ No ☐ Will receive assistance

Do you have a Financial Power of Attorney (POA) or Living Trust established? ☐ Yes* ☐ No

*Please provide a copy of POA or Trust Document to Springside at Seneca Hill.

Name of Power of Attorney (POA) or Trust Administrator _____

Address _____

Telephone _____

If your monthly invoices should be sent to someone other than you, please give that person's name, full address, and telephone number below:

_____

_____

_____

SECTION V – HOUSING PREFERENCE

CONGREGATE APARTMENTS

☐ One-bedroom deluxe

☐ Two-bedroom suite

DUPLEX DWELLINGS & COTTAGE UNITS

☐ Style "A"

☐ Style "B"

☐ Cottage Unit

SECTION VI – SERVICE CHOICES

☐ One meal per day

☐ Two meals per day

☐ Three meals per day

☐ Garage Parking

☐ Personal Laundry

☐ Cleaning

☐ Transportation

SECTION VII – HEALTH/MEDICAL INFORMATION

Primary Care Physician _____

Address: (Street, City, State, Zip Code) _____

Telephone: _____

Specialists:

NAME	SPECIALITY	ADDRESS(Street, City, State, Zip)	PHONE
1.			
2.			
3.			
4.			

Dentist(s) _____

Address (Street, City, State, Zip Code) _____

Telephone _____

Do you plan to continue your relationship with your current health-care providers(s)?

☐ Yes* ☐ No ☐ Uncertain

*NOTE: Referral to local physicians is available. Please speak with Resident Director.

SECTION VII – HEALTH MEDICAL INFORMATION CONT.

Would you like recommendations for deciding upon local health care professionals?

☐ Yes ☐ No ☐ Uncertain

Describe your current health condition _____

_____

_____

Applicant

Medicare# _____ Secondary Insurance Company _____

Policy# _____ Group# _____

Co-Applicant

Medicare# _____ Secondary Insurance Company _____

Policy# _____ Group# _____

Do you have a Medical Power of Attorney ("Health Care Proxy") in NY State? ☐ Yes ☐ No

If yes, who is your Health Care Proxy? _____

Address _____ Phone _____

Who should we notify in the event of an emergency?

Name _____

Address _____

Phone _____

Do you have a Last Will and Testament? ☐ Yes ☐ No

Who will be the Executor of your will?

Name _____

Address _____

Phone _____

Please indicate which funeral home should be contracted in the event of your death:

Name _____

Address _____

Phone _____

SECTION VII – HEALTH MEDICAL INFORMATION CONT.

Will you need any of the following services upon moving to Springside? (Check all that apply)

☐ Health Counseling/advice ☐ Weight Monitoring

☐ Blood Pressure checks (1x per week)

SECTION VIII – DISCLOSURES

Springside at Seneca Hill, Inc. is a not-for-profit corporation in New York State governed by a Board of Directors.

Springside practices non-discrimination in the promotion of dwelling units and in the execution of Residency Agreements. Residency will not be denied to any person because of sex, race, religion, handicap or national origin.

An Offering Plan; disclosure document was filed with the New York State Department of Law and approved by the State Attorney General as of April 2, 1999. This Offering Plan is available upon request for you to inspect if you so desire. Please request a copy from the Chief Operating Officer.

A $500 non-refundable reservation fee is required to reserve a living unit or to be placed on the waiting list. This application should be completed prior to reserving a unit. Once submitted, it will be reviewed. If additional information is needed to complete the application process you will be notified. An applicant who does not meet residency criteria may be denied occupancy. Each applicant will be notified as to the status of his/her application, in writing, within five to fourteen days after receipt of the application.

APPLICANT SIGNATURE

I understand that my application will be reviewed upon receipt and I will be notified regarding acceptance for residing at Springside at Seneca Hill within 5 to 14 days.

Applicant's Signature_____

Co-Applicant's Signature_____

Date_____