



Springside at Seneca Hill

An Affiliate of Oswego Health

Application for Residency

Springside at Seneca Hill, Inc.
10 County Route 45A
Oswego, NY 13126



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

CONFIDENTIAL DOCUMENT

www.oswegohealth.org
315-343-5658 • Fax: 315-207-0179
10 County Route 45A, Oswego, N.Y. 13126

SECTION 1 • 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

SECTION III • PERSONAL HISTORY cont.

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" _____ Cottage Unit

_____ Style "B"

SECTION VI • SERVICE CHOICES

_____ One meal per day _____ Garage parking _____ Cleaning

_____ Two meals per day _____ Personal Laundry _____ Transportation

_____ Three meals per day _____ Clerical Assistance _____ Personal Support management

Wellness services _____ Assistance to manage special diet

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 provider(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/advise

____ Weight Monitoring

____ Blood Pressure checks (1x per wk)

____ Medication Set Up (Chargeable svc)

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 _____

