Partridge Knoll, ILC
Independent Retirement Community
30 Sullivan Drive, Canton NY 13617 ■ (315) 379-1428

Application for Residency and Financial Disclosure

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 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: _____________________________________ SSN: ______________________

Preferred Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other: _____________________________

A United Helpers Community

Current Residence:
How long have you lived at your present address? ___________________

Do you: ☐ Own ☐ Rent Your current home?

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

If you are a homeowner:

Do you plan to sell 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:

A. **Income**: Please indicate the appropriate rand of your total annual income. (Sources of income include Social Security and pension benefits, as well as rental income, interest, etc.)

☐ $10,000 or less ☐ $10-$15,000 ☐ $15-$20,000
☐ $20-$25,000 ☐ $25-$35,000 ☐ $35,000 or more

B. **Assets**: Please indication the appropriate range for the total value of your assets. (Assets include savings and investments, such as CDs, stocks, bonds, mutual funds, insurance, annuities, etc.)

☐ $10,000 or less ☐ $10-$20,000 ☐ $20-$30,000
☐ $30-$40,000 ☐ $40-$50,000 ☐ $50-$75,000
☐ $75-$100,000 ☐ $100-$150,000 ☐ $150,000 or more

C. **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-$75,000 ☐ $75-$100,000 ☐ $100-$150,000 ☐ $150,000 or more

Financial Affairs

Will you be handling your own financial affairs? ☐ Yes ☐ No ☐
Have you established a Power of Attorney (POA)
or a 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: ☐ St. Regis ☐ Raquette ☐ St. Lawrence
☐ Valley ☐ Southwood ☐ 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 ☐

Health/Medical Information:

Primary Care Physician: ________________________________ Telephone: ____________

Full Address: ____

Describe your current health condition:
____
____
____

Current health condition, cont'd: ____
____
____

Well Being Checks:

Do you wish to participate in daily well-being checks? (Included in your service package.) ☐ Yes ☐ No ☐

Emergency Contacts:

1) Name: ______________________________ Telephone Number: ________________

Address: ____

Relationship to Applicant: ____

2) Name: ______________________________ Telephone Number: ________________

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 healthcare 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

Revised 6/7/1999