Loudonville Assisted Living_____ Gerald Levine Center for Memory Care_____
Enhanced Assisted Living_____

Resident Name _____DOB_____

Religon_____Sex_____SS#_____

Responsible Person_____ Relationship _____

Street_____

City, State, Zip_____

Email_____Phone_____

Attending Physician _____Phone_____

Street_____

City, State, Zip_____

Other Health Care Providers, If any_____

Street_____

City, Street, Zip_____

Phone_____Fax_____

Health Insurance Information

Plan Name _____ **Plan #**_____

Other Health Insurance _____ **Plan #**_____

Please attach copies of each card

Area Hospital of Choice _____ **Phone**_____

Address_____

Emergency Contact_____

Address_____

Home Phone _____ **Work Phone** _____ **Cell**_____

Present Residence

Nursing home_____ **Hospital**_____ **Own home**_____ **Other**_____

Current Address_____

Please provide date you expect to become a resident of the home_____

_____

Financial Information

Monthly Income_____ **Assetts**_____

Social Security _____ **Real Estate**_____

Pension_____ **Other**_____

Dividends_____ **Other**_____

Total Monthly Income _____ **Total Assets**_____

Do you have any liabilities that may reduce your income? _____

_____

Family Contacts

Name_____**Relationship**_____

Address_____

Email_____**Phone**_____

Name_____ **Relationship**_____

Address_____

Email_____**Phone**_____

It is understood that all information given in this application is true and correct.

Signature_____**Date**_____

Signature_____**Date**_____