Parkside Independence

LECOM HEALTH

LECOM HEALTH
INDEPENDENT/PERSONAL CARE

APPLICANT

Last Name:_____First_____ MI: _____

Social Security Number ____-____-____ Birth Date _____/_____/_____

Home Phone:_____ Cell:_____ Work: _____

Marital Status _____

Home Address: _____ City/State/Zip:_____

Driver's License Number: _____State Issued: _____ License Plate: _____

Occupation:_____

Email Address:_____

CO-APPLICANT

Last Name:_____First_____ MI: _____

Social Security Number ____-____-____ Birth Date _____/_____/_____

Home Phone:_____ Cell:_____ Work: _____

Marital Status _____

Home Address: _____ City/State/Zip:_____

Driver's License Number: _____ State Issued: _____

Occupation:_____

Email Address:_____

EMERGENCY CONTACT INFORMATION

Last Name:_____First_____ MI: _____

Home Phone: _____ Cell: _____ Work: _____

Relationship: _____

MEDICAL

Member of Millcreek Paramedics? Yes / No

Member of Emergycare? Yes / No

Member of LIFT? Yes / No

Primary Physician

Physician's Name:_____

Physician's Phone Number: _____

Physician's Address: _____

Email Address:_____

Secondary Physician

Physician's Name:_____

Physician's Phone Number: _____

Physician's Address: _____

Primary Insurance

Name of Provider:_____

ID Number: _____

Group Number: _____

Power of Attorney

Name:_____

Phone Number: _____

Address:_____

Relationship: _____

FINANCIAL

Monthly Income

Social Security: _____

Pension _____

Investment Income: _____

Other Income: _____

Total Monthly Income: _____

Assets - Estimated Amounts/Values

Cash Accounts (Checking and Savings): _____

Investment Account Value: _____

Current Home/Estimated Value: _____

Investment Property/Estimated Value: _____

Life Insurance: _____

Long Term Care Insurance: _____

Other Assets: _____

Liabilities

Current Home - Monthly Payment: _____ Loan Balance: _____

Second Home - Monthly Payment: _____ Loan Balance: _____

Vehicle 1 - Monthly Payment: _____ Loan Balance: _____

Vehicle 2 - Monthly Payment: _____ Loan Balance: _____

Consumer Debt - Monthly Payment: _____ Loan Balance: _____

CO-GUARANTOR

Last Name:_____First_____ MI: _____

Email Address:_____

Social Security Number ____-____-____ Birth Date _____/_____/_____

Home Phone: _____ Cell: _____ Work: _____

Home Address: _____ City/State/Zip:_____

Employer: _____

Occupation:_____

Monthly Income: _____

❑ I UNDERSTAND A MEDICAL/HEALTH ASSESSMENT WILL BE PERFORMED BY AN EMPLOYED MEDICAL PROFESSIONAL. I FURTHER UNDERSTAND THAT RESIDENCY WILL BE CONTINGENT UPON A SATISFACTORY ASSESSMENT.

BY SIGNING THIS APPLICATION, YOU DECLARE THAT ALL OF YOUR RESPONSES ARE TRUE AND COMPLETE AND AUTHORIZE MANAGEMENT OF PARKSIDE SENIOR LIVING COMMUNITIES TO VERIFY THIS INFORMATION, REFERENCES, CREDIT RECORDS AND EMPLOYMENT STATUS. ANY FALSE STATEMENT ON THIS APPLICATION CAN LEAD TO REJECTION OF YOUR APPLICATION OR IMMEDIATE TERMINATION OF YOUR LEASE.

Applicant Signature: _____ Date: _____

Co-Applicant Signature:_____ Date: _____

Co-Guarantor Signature: _____ Date: _____

OFFICE USE ONLY

❑ Regency ❑ Westminster ❑ North East

❑ Studio ❑ 1 Bedroom ❑ 2 Bedroom