Fox Run at Orchard Park
Confidential Data Application
— CDA —

Please Print Clearly or Type

Salutation: ______________

Name: ____
Last First Middle

Address: ____
Street

____
City State Zip Code

Contact Info:

Home Phone: ____

Work Phone: ____

Cell Phone: ____

E-mail: ______________________@______________________

Resident Social Security No.: ____________________

U.S. Citizen? Y / N Veteran? Y / N

Birth Date: ________/________/________
Month Day Year

Marital Status: Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated ❑

Salutation: ______________

Name of Spouse/2nd Person: __________________ Birth Date: ______/______/______
Month Day Year

Spouse/2nd Person Social Security No.: _______________ U.S. Citizen? Y / N Veteran? Y / N

Primary Emergency Contact:

Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip Code

Telephone No.: Home: ________________ Work: ______________ Cell: ______________

E-mail: ______________________@______________________________

Power of Attorney/Guardian/Health Care Agent (if more than one person, please list all on an attachment):

Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip Code

Telephone No.: Home: ________________ Work: ______________ Cell: ______________

E-mail: ______________________@______________________________

Billing Party (if other than resident):

Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip Code

Telephone No.: Home: ________________ Work: ______________ Cell: ______________

E-mail: ______________________@______________________________

Primary Physician:

Name: ______________________________ Phone: ______________ Fax: ______________

Address: ____
Street City State Zip Code

E-mail: ______________________@______________________________

Consulting Physician (specialist): (*if applicable*)

Name: ______________________________ Phone: ______________ Fax: ______________

Address: ____
Street City State Zip Code

E-mail: ______________________@______________________________

Insurance Coverage:

Medicare No. (Resident): ______________________________ Part A: ________ Part B: ________

Prescription Drug Plan: ________________________________ Effective Date: ________________

Rx Group ID: ____________ Rx Group: ____________ Rx Bin: ____________ Rx PCN: __________

Supplemental Health Insurance: ____________________________ Policy No.:_________________

Medicare Advantage Plan: ________________________________Policy No.: _________________

Medicare No. (Spouse/2nd person): _______________________ Part A: ________ Part B: ________

Prescription Drug Plan: ________________________________ Effective Date: ________________

Rx Group ID: ____________ Rx Group: ____________ Rx Bin: ____________ Rx PCN: __________

Supplemental Health Insurance: ____________________________ Policy No.:_________________

Medicare Advantage Plan: ________________________________Policy No.: _________________

LONG TERM CARE INSURANCE	1st Person	2nd Person
Insurance Company Name (attach copy)		
Policy Number	#	#
Annual/Monthly Premium	$	$
Benefit Period	Years	Years
Elimination Period	Days	Days
Assisted Living Benefit Amount	$ Day	$ Day
Skilled Nursing Benefit Amount	$ Day	$ Day
Home Care Benefit Amount	$ Day	$ Day
Maximum Coverage	$	$
Inflation Coverage	%	%

Family and/or Emergency Contact Preference:

Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip Code

Telephone No.: Home: ________________ Work: ______________ Cell: ____________

E-mail: ___________________________@_____________________________

Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip Code

Telephone No.: Home: ________________ Work: ______________ Cell: ____________

E-mail: ___________________________@_____________________________

Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip Code

Telephone No.: Home: ________________ Work: ______________ Cell: ____________

E-mail: ___________________________@_____________________________

Name: ______________________________ Relationship: ____________________

Address: ____
Street City State Zip Code

Telephone No.: Home: ________________ Work: ______________ Cell: ____________

E-mail: ___________________________@_____________________________

FINANCIAL STATEMENT

REGULAR MONTHLY INCOME	1st Person	2nd Person
Social Security	$	$
Pension*	$	$
IRA Income	$	$
Dividends	$	$
Mortgage/Rental Income	$	$
Trust Income	$	$
Other Monthly Inc. source:	$	$
Total Regular Monthly Income	$	$
CAPITAL ASSETS	1st Person	2nd Person
House(s)	$	$
Stocks	$	$
Bonds	$	$
IRA's	$	$
Annuities	$	$
CD's	$	$
Savings	$	$
Checking	$	$
Mutual Funds	$	$
Trust Fund (attach copy)	$	$
Life Insurance (cash value)	$	$
Other Real Estate source:	$	$
Other Assets	$	$
Total Assets	$	$
LIABILITIES		
Mortgage	$	$
Other Debts (ie. credit card, loans, etc.)	$	$
Automobile Loan(s)	$	$
Total Liabilities	$	$

SUPPORTING DOCUMENTATION

❏ Tax Return ❏ Life Insurance ❏ Investment Statements ❏ Bank Statements

1st Person *What occurs at death of spouse? ❏ Pension ceases ❏ Pension reduces _____% ❏ No change

*Does the Pension amount increase with inflation? ________ If so, describe:

2nd Person *What occurs at death of spouse? ❏ Pension ceases ❏ Pension reduces _____% ❏ No change

*Does the Pension amount increase with inflation? ________ If so, describe:

Have you transferred any asset valued over $1,000 in the past five (5) years? Yes ________ No ________

If yes, please indicate the specifics of any transfer indicating the asset, the fair market value, to whom the asset was transferred, and the date of the transfer. Fox Run reserves the right to request official documentation of any such transfer. Your failure to disclose this information may affect your admission application.

I hereby declare that all statements made herein are true according to my best knowledge and belief. In witness whereof, I have hereunto set my hand to this application this ________ day of ______________________ 20_____.

____ ____

Signature of 1st Person/POA/Responsible Party **Signature of 2nd Person**

Notes / Comments:

livelife.

Fox Run at Orchard Park
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foxrunorchardpark.com

EQUAL HOUSING OPPORTUNITY