Springwater Memory Support Assisted Living Application

First Occupant Information

Mr./Mrs./ Ms. First________________________Last___________________Middle_____________

Nickname_______________Address:____

City:____________________State:_________Zip:____

Home Phone (_____)______________________ Cell Phone (_____)_____________________

Medicare #______________________________ Social Security #_________________________

Secondary Insurance Name and #: ____
(Copies of current insurance and ID cards are required)

Date of Birth:____________________________ Wedding Anniversary Date:________________

Previous Occupation______________________ Branch of Military Service _________________

Emergency / Primary Contact Information

1st Primary Emergency Contact Information

Person to notify in case of emergency: Name:__________________________Relation:_____________

Address:________________________________ City:_____________________State:_____ Zip: _____

Home Phone: (_____)______________________
Cell Phone: ( )______________________
Email address (required):____

2nd Emergency Contact Information

Name:___________________________Relation:_____________

Address:________________________________ City:_____________________State:_____ Zip:______

Home Phone: (_____)______________________
Cell Phone: (_____)______________________

Email address (required):____

3rd Emergency Contact Information

Name:___________________________Relation:_____________

Address:________________________________ City:_____________________State:_____ Zip:______

Home Phone: (_____)______________________
Cell Phone: (_____)__________________
Email address (required):____

4th Emergency Contact Information

Name:___________________________Relation:_____________

Address:________________________________ City:_____________________State:_____ Zip:______

Home Phone: (_____)______________________
Cell Phone: (_____)__________________
Email address (required):____

Personal Physician(s)

First Occupant. Physician Name____

Address_________________________________City:________________________State:___________

Zip:_________________Phone (_____)________________________

If someone other than you administers your finances, please complete the following:

Family Member Name: ______________________________ Relationship______________________

Address ____ City ____________________________

State _________________________________ Zip ___________________

Home Phone: ( ) ___________________________ Cell Phone: ( )_____________________

Email Address: ____

Durable / Financial Power of Attorney Name:_____________________Relationship:____________

Address:______________________City________________________State:_______Zip:_____________

Home Phone: ( ) ___________________________ Cell Phone: ( )_____________________

Email Address: ____

Trust officer Name:___________________________Address:________________________________

City:________________________Zip:_________State:_____Phone:____________________________

Attorney Name:___________________________Address:_________________________________

City:________________________Zip:_________State:_____Phone:____________________________

Children

Name:________________________ Address:____

City:______________________ State:_______Zip:________________Phone:____________________

Name:________________________ Address:____

City:______________________ State:_______Zip:________________Phone:____________________

Name:________________________ Address:____

City:______________________ State:_______Zip:________________Phone:____________________

Apartment Selection:

Springwater apartment style requested: (Circle one)

Standard Studio | Deluxe Studio | Deluxe Studio Plus

Procedure

1) _____Submit Application Form and Confidential Financial Information Form

2) _____Wait for Waterman Village to review application. If approved…

3) _____Submit $1,200 non-refundable Community fee (Payable to Waterman Communities, Inc.)

Check # _____________ **Received by** _________________________ **Date** _______________

A Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823, is required for all residents. This assessment, which requires a face to face assessment, is to be completed by your physician prior to moving in to the Bridgewater.

I (We) declare the information in this application to be true, full and complete. I (We) give Waterman Village permission to verify the information in this application.

______________________________________ ________________________

Signature (First Applicant or POA) Date

______________________________________ ________________________

Signature (Second Applicant if applicable) Date

______________________________________ ________________________

Waterman Village Representative Date

ASM 03/12/24