



WATERMAN VILLAGE
Bridgewater 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 _____

Email Address: _____

Vaccinated: Y / N If yes, circle type: Pfizer, Moderna, Johnson & Johnson
(Please provide a copy of your card for our records)

Second Occupant Information (If applicable)

Mr./Mrs./ Ms. First _____ Last _____ Middle _____

Nickname _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Medicare # _____ Social Security # _____

Secondary Insurance _____

Date of Birth: _____ Wedding Anniversary Date: _____

Previous Occupation _____ Branch of Millitary Service _____

Email Address: _____

Vaccinated: Y / N If yes, circle type: Pfizer, Moderna, Johnson & Johnson
(Please provide a copy of your card for our records)

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 () _____

Second 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: _____

Pets

Do you have a pet? Y / N

If yes, what type? Cat / Dog If dog, what breed and size? _____

Will pet reside in facility? Y / N

Does your pet have current vaccination records? Y / N

Apartment Selection

Bridgewater apartment style requested: (Circle one)

Azalea

Hibiscus

Camellia

Gardenia

Magnolia

Dogwood

Respite Stay

Please indicate the dates of Respite Stay: _____

Procedure
(Not applicable to Respite Stays)

- 1) _____ Submit Application Form and Confidential Financial Information Form
- 2) _____ Wait for Waterman Village to review application. If approved...
- 3) _____ Submit \$2,000 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
ASM 02/10/2025

Date