Canterbury Inn Application for Residency

Canterbury Inn
Supervised Senior Residence
46 Cherry Street St. Johnsbury, Vermont 05819
(802) 748-5556

Applicant Name: _____

Monthly Income: _____

Date of Application: _____

Please select your color preference. Whenever possible we will coordinate painting rooms based on your selection.

This form is admittedly lengthy; however, the information you provide will help us determine if the Canterbury Inn will be able to meet you housing and care needs. Please complete this form in its entirety and return it to the Director. We do not consider anyone for residency until this form is completed, dated, signed and returned to the Director.

If the applicant has a guardian, the guardian must sign this application. **A copy of the Court Order appointing the guardian must accompany this application.**

If you require assistance completing this application, or have any questions regarding the application contents, please call the Canterbury Inn at (802) 748-5556 and ask to speak with one of the Directors.

Application acceptance is based in part on the following factors:

- The ability of the prospective resident to live independently given the availability of supportive services customarily provided at the Inn
- The need of the prospective resident for one or more of the supportive services customarily provided at the Inn
- The income of the prospective resident

The Canterbury Inn remains one of the lowest cost assisted living facilities in New England.

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Demographic Information

Name: _____

Current Address: _____

_____

Phone Number: _____

E-Mail Address: _____

Date of Birth: _____ Sex: Male Female

Religion: _____

Social Security Number: _____ Citizen of the US: Yes No

Name of nearest relative or significant other #1: _____

Address: _____

_____

Phone Number: _____ (H) _____ (W or C)

E-Mail Address: _____

Name of nearest relative #2: _____

Address: _____

_____

Phone Number: _____ (H) _____ (W or C)

E-Mail Address: _____

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Insurance Information

Medicare Part A Number: _____

Medicare Part B Number: _____

Effective Date: _____

Medicaid Number: _____

Effective Date: _____

List names and account numbers of other medical or prescription insurances:

_____

_____

_____

COPIES OF ALL INSURANCE CARDS MUST BE PROVIDED WITH THIS APPLICATION

Do you have pre-paid or pre-arranged funeral arrangements: Yes No

If yes, where? _____

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Medical Provider Information

Primary Care Physician: _____

Practice Name: _____

Phone Number: _____ Last Seen: _____

Will you be retaining this physician during residency at the Canterbury Inn? Yes No

If you plan to change physicians, which practice are you considering?

_____

Do you see any medical specialists? Yes No

If yes; please list:

Provider Specialty Last Seen

_____

_____

_____

_____

Who is your dentist? _____

Who is your ophthalmologist? _____

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Personal Affairs

Do you handle your own affairs? Yes No If no, who handles your affairs?

Name: _____

Address: _____

Phone Number: _____ (H) _____ (W or C)

E-Mail Address: _____

Do you have a Power of Attorney? Yes No

If yes, name: _____

Address: _____

Phone Number: _____ (H) _____ (W or C)

E-Mail Address: _____

POWER OF ATTORNEY DOCUMENTATION MUST BE SUBMITTED WITH THIS APPLICATION

Do you have a Guardian? Yes No

If yes, name: _____

Address: _____

Phone Number: _____ (H) _____ (W or C)

E-Mail Address: _____

COURT ORDER APPOINTING GUARDIANSHIP MUST ACCOMPANY THIS APPLICATION

Do you have advanced directives? i.e. Living Will, Durable Power of Health Care: Yes No

IF YES, A COPY MUST BE SUBMITTED WITH THIS APPLICATION

If no, would you like to set up an appointment with the local Ombudsman to establish directives?

Yes No N/A

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Personal Notes

Please tell us why you are interested in moving to the Canterbury Inn:

_____

_____

_____

_____

_____

What did you do for work most of your life?

_____

_____

What are your hobbies?

_____

_____

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Functional Assessment

Height: _____ Weight: _____

- During the past six months, how many times have you seen a doctor? _____

- During the past six months, how many days were you so sick you were unable to carry on your usual activities?

None 1 Week or Less More than a Week

- In the past six months, how many times have you been in the hospital for physical health problems? _____

- How would you rate your overall health at the present time?

Excellent Good Fair Poor

- How would you rate your health in comparison to a year ago?

Better About the Same Worse

- How much do your health problems stand in the way of your doing the things you want to do?

Not at All A Little A Great Deal

- Do you have periods of confusion or forgetfulness that interfere with your daily activities?

Yes No

- Have you been diagnosed with a mental illness? Yes No

- How would you rate your current mental health: Excellent Good Fair Poor

- How would you rate your mental health now vs. a year ago? Better Similar Worse

- Are you currently on any medication(s) for mental illness? Yes No

- Are you seen by a mental health facility or psychiatrist on a regular basis? Yes No

- Do you have any problems with your health based upon drinking or drug use? Yes No

- Has your doctor advised you to reduce your drinking or drug use? Yes No

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- Taking everything into consideration, how would you describe your satisfaction with life in general at the present time?

Excellent Good Fair Poor

- Is your sleep disturbed? Yes No

- Are you bothered by your heart pounding or shortness of breath? Yes No

- Do you have difficulty keeping your balance while standing or walking? Yes No

- How is your eyesight? Good Fair Poor Glasses/Contacts Blind

- How do you walk? Alone Alone, with an assistive Device With the help of 1 person

With the help of 2 people Cannot Walk

- Are you able to use a telephone without assistance? Yes No

- Can you feed yourself? Without Help With some Help Not at all

- Can you handle your own money? Without Help With Some Help Not at all

- Can you dress/ undress yourself? Without Help With some Help Not at All

- Can you take care of your own appearance? Without Help With some Help Not at All

- Can you get in and out of bed? Without Help With some Help Not at all

- Can you take a bath or shower on your own? Without Help With some Help Not at All

- Do you ever have trouble getting to the bathroom on time? Yes No

- Do you have a catheter or colostomy? Yes No

- How often do you wet or soil yourself per week? (Day or night) 0 1-2 3-5 6+

- Do you have your own teeth? Yes- Good Repair Yes- Bad Repair No

- During the past six months, have you had any help with such things as shopping, housework, bathing, dressing and getting around?

Yes No

If yes, who is the primary person to help you with this?

Name: _____ Relationship: _____

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Medical Survey

Do you have any of the following illnesses? Please select Yes or No for each listing.

	Yes	No
Arthritis or Rheumatism	____	____
Glaucoma	____	____
Asthma	____	____
Emphysema or Chronic Bronchitis	____	____
Tuberculosis	____	____
High Blood Pressure	____	____
Heart Trouble	____	____
Circulation Trouble in Arms or Legs	____	____
Diabetes	____	____
Ulcers (of digestive system)	____	____
Stomach or Intestinal Disorders	____	____
Cancer or Leukemia	____	____
Anemia	____	____
Effects of Stroke	____	____
Parkinson's Disease	____	____
Epilepsy	____	____
Cerebral Palsy	____	____
Multiple Sclerosis	____	____
Effects of Polio	____	____
Thyroid or Glandular Disorders	____	____
Pressure Sores, Leg Ulcers or Burns	____	____
Speech Impediment or Impairment	____	____
Dementia	____	____
Alzheimer's	____	____

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Do you use any of the following devices? Please answer Yes or No for each listing.

	Yes	No
Wheelchair	____	____
Cane	____	____
Walker	____	____
Prosthesis	____	____
Glasses or Contacts	____	____
Hearing Aid	____	____
Dentures- Top	____	____
Dentures- Bottom	____	____

Are you taking prescription medications? Yes No

If yes, please provide a list of these medications when submitting this application

Are you taking over-the-counter medications or vitamins? Yes No

If yes, please provide a list of these medications/supplements when submitting this application

Please list ALL of your known allergies, including food allergies:

_____ _____

_____ _____

_____ _____

Please list ALL special dietary needs:

_____

_____

_____

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Financial Survey

- **Income:** List all income from all sources, including but not limited to wages/Salary, Social Security, pensions, Worker's Compensation, alimony, annuities, dividends, proceeds from rental properties, interest, etc. Attach an additional sheet if necessary.

Source	Am't Rec'd	Frequency	Name/Address for verification
_____			
_____			
_____			
_____			

- How many people are supported by your income? _____

- **Assets:** List all banking accounts, include savings, checking, stocks and bonds, CDs, cash value of life insurance, etc. Do not include real estate. Attach an additional sheet if necessary.

Asset	Name/Address for verification	Acct. #	Value
_____			
_____			
_____			
_____			
_____			

- **Real Estate:** List all real estate in which you have ownership interest.

Type & Address	Fair Market Value	Mortgage Holder	Mortgage Balance
_____			
_____			
_____			

- Do you have any other financial support not listed previously on this application? Yes No

If yes, explain: _____

_____

_____

- **Expenses:** List all expenses you pay on a regular basis such as rent, utilities, car payments, insurance, etc.

_____

_____

_____

_____

_____

_____

- **Changes:** Do you anticipate any changes in income or assets (including real estate) within the next 12 months?

Yes No

If Yes, explain: _____

_____

_____

_____

- State any other information which you would expect to be helpful in processing this application:

_____

_____

_____

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Disclaimer and Release

The information contained in this application is to be used by Canterbury Inn and its operating company CBI, Inc. to assist in determining the eligibility and sustainability of the applicant for residency at the Inn and services which may be required. By law, the Vermont Department of Health is entitled to a resident's health and medical records for the purpose of licensing and certification.

STATEMENT OF APPLICANT OR LEGALLY AUTHORIZED REPRESENTATIVE

I certify that all of the information provided on this form is true and complete to the best of my knowledge and belief.

_____	_____
Signature of Applicant	Signature of Legal Representative
_____	_____
Printed Name of Applicant	Printed Name of Legal Representative
_____	_____
Date	Date

Authorization for the Release of Information

I, _____ do hereby give my permission to release any medical records which may be deemed useful in maintaining the continuation of my care, to the nursing staff of Canterbury Inn. I also give my permission for the Canterbury Inn Care Attendants and Administrative staff to share my information with any and all other health professionals who are or may become involved in my care.

_____	_____
Signature of Applicant	Signature of Legal Representative
_____	_____
Printed Name of Applicant	Printed Name of Legal Representative
_____	_____
Date	Date