



Admissions Application

Applicants Name: _____ Date of Birth: _____

Mailing Address: _____

Marital Status: M W D S SSN#: _____

Medicaid #: _____ Medicare #: _____

Other Health Insurance Provider: _____ ID #: _____

Provider #: _____ Policy #: _____

Do you have Long Term Care Insurance? Yes No

Are you enrolled in the State of Vermont Choices for Care Program? Yes No

If yes, name of caseworker and agency: _____

Are you being admitted from home? Yes No

Do you have Home Health Services? Yes No

If yes, name of home health provider and organization:

Contact Information:

Name of Legal Financial Representative: _____ Relationship: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Other Phone #: _____



Name of Legal Health Care Representative: _____ Relationship: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Other Phone #: _____

Name of Power of Attorney: _____ Relationship: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Other Phone #: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Other Phone #: _____

Additional Contact Information (children, relatives or friends involved in your care)

Name: _____ Relationship: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Other Phone #: _____



Name: _____ Relationship: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Other Phone #: _____

Name: _____ Relationship: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Other Phone #: _____

Do you have a Living Will or Advanced Care Directive? Yes No

CPR DNR

Do you have funeral arrangements made? Yes No

If yes, name of funeral home: _____ Phone #: _____

Address: _____

Do you suffer from incontinence? Urine Bowel Both

Do you currently have Dentures? Yes No

Upper Lower Both

Do you currently use Hearing Aids? Yes No

Left Right Both



Do you use alcohol? Yes No

Do you use tobacco? Yes No

Do you need assistance with transfers? (Ex: sitting to standing, in/out of bed)

Yes No Sometimes

Do you need assistance getting dressed?

Yes No Sometimes

Financial Information

To assist with your financial planning during your stay at Brownway Residence, please complete the following:

(Per Month)

Social Security	\$	Retirement/Pension	\$
SSI	\$	Annuities/Investments	\$

Real Estate Assets

Do you own a home? Yes No

If yes, what is the approximate value: \$_____

Is the property co-owned? Yes No

If yes, what is the co-owners name: _____

Do you own additional property? Yes No

If yes, what is the approximate value: \$_____

Life Insurance Cash Value:

Do you have life insurance policies with cash value? Yes No

If yes, cash value is: \$_____



Cash Assets in Banks, Credit Unions, Savings and Financial Institutions

Name of Institution: _____ Location: _____

Balance: \$ _____ Name on Account: _____

Name of Institution: _____ Location: _____

Balance: \$ _____ Name on Account: _____

Name of Institution: _____ Location: _____

Balance: \$ _____ Name on Account: _____

PRIVACY ACT STATEMENT: The information on this application is to be used by Brownway Residence to assist in determining eligibility and suitability of the applicant for residency at Brownway and services which may be required. The Vermont Department of Aging and Disabilities licenses Brownway Residence, and thus is entitled to access the resident's records for the purpose of licensing and qualification. Appropriate authorization will be obtained from the applicant, or the applicants legally authorized representative, prior to release of information on this form to persons or entities other than the Department of Aging and Disabilities and Brownway Residence.