Living Well Group
Elder Care Communities Honoring the Individual

Ethan Allen Residence
a Living Well Group Community

Heaton Woods Residence
a Living Well Group Community

Ethan Allen Residence Application

Consideration for residency is based in part on the following factors:

1. Ability of the prospective resident to live independently given the availability of supportive services
2. Need of the prospective resident for one or more of the supportive services customarily provided here
3. The income of the prospective resident

How to complete this admission application:

To be considered for residence, the applicant must complete all pertinent sections of this application, sign and date the application, and return it to:

Shannon Robtoy, Administrator
1200 North Avenue, Burlington, VT 05408
ethanallen@livingwellgroup.org

If the applicant has a guardian, this application must be signed by the guardian. Admission cannot be completed without a copy of the court order appointing the guardian.

If assistance is needed in completing this application, please call 802-391-8851

PERSONAL INFORMATION

Full Name: _____
First Middle Last

Preferred Name: _____

Date of Birth: _____ Place of Birth: _____ Sex: M / F

Social Security Number (SSN): _____ - _____ - _____

Marital Status (circle): Single Married Widowed Divorced

APPLICANT CONTACT INFORMATION

Current Mailing Address:

_____

Street Address Apt/Suite

_____

City State Zip Code

Email: _____

Cell Phone: _(_____)_____ Home Phone: ( ) _____

Preferred Contact Method: _____

RELEVANT OR RESPONSIBLE CONTACT INFORMATION

Current Mailing Address:

_____

Street Address Apt/Suite

_____

City State Zip Code

Email: _____

Cell Phone: _(_____)_____ Home Phone: ( ) _____

Preferred Contact Method: _____

GENERAL INFORMATION

1. Primary Care Physician:

   _____ _____

   Name Phone #

   _____

   Email

   Do you plan to retain this physician? (circle): Yes No

2. Do you handle your own business affairs? (circle): Yes No

If no, who handles these affairs? _____ _____

Name

_____ _____

Relationship to Applicant Phone #

_____

Address

_____

Email

3. Why would you like to be considered for admission to Heaton Woods Residence?

_____

_____

_____

_____

4. What did you do for work most of your life?

_____

_____

_____

5. What are your interest/hobbies?

_____

_____

_____

FUNCTIONAL ASSESSMENT

1. Please describe your current health issues:

_____

_____

_____

_____

2. How do these issues impact your daily life?

_____

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

_____

3. During the past six months, how many days were you so sick that you were unable to carry on your usual activities? (circle):

None A week or less More than a week

4. During the past six months, were you in a hospital for health issues? (circle): Yes No

If yes, how many days were you hospitalized? _____

5. What sort of health issues were you hospitalized for? _____

6. How would you rate your overall health at the present time? (circle):

Excellent Good Fair Poor

7. How would you rate your overall health compared to a year ago? (circle):

Better About the same Worse

8. How much do your health issues stand in the way of your doing the things you want to do? (circle):

Not at all A little A great deal

9. Do you have periods of confusion or forgetfulness that interfere with your daily activities? (circle): Yes No

10. Please circle all that apply to your mental status:

Confused Forgetful Difficulty expressing self

Wandering Sociable Withdrawn Depression

Anxiety

11. Please list your medications including dosages, frequency, and time of day. Please include supplements and over the counter medications as well:

_____

_____

_____

_____

_____

_____

_____

What other medications (short-term) have you taken in the past month?

_____

_____

_____

12. Do you need assistance taking medications? (circle): Yes No
If yes, please describe:

_____

_____

13. Are you allergic to any medications or foods? (circle): Yes No
If yes, please describe any reactions you have experienced:

_____

_____

Do you have any dietary restrictions? (circle): Yes No
If yes, please describe:

_____

_____

14. Do you have difficulty eating or drinking? (circle): Yes No

    If yes, please describe:

    _____

    _____

15. Do you use any of the following aids? (circle):

    Wheelchair Cane Walker Glasses

    Contact Lenses Dentures Hearing Aid

    Other: _____

16. How is your eyesight? (circle):

    Excellent Good Fair Poor Totally Blind

    Other: _____

17. Have you ever had a drinking problem or has your doctor ever advised you to cut down on drinking? (circle): Yes No

18. Do you use tobacco/nicotine products including chewing tobacco? (circle): Yes No

19. Do you use marijuana? (circle): Yes No

20. Do you feel that you need medical care or treatment beyond what you are receiving at this time? (circle): Yes No

    If yes, please describe:

    _____

    _____

21. How well do you walk? (circle):

    Alone Alone with a cane, walker, etc

Only with the help of another person Cannot walk

22. Do you have difficulty keeping your balance while walking? (circle): Yes No

23. Is your sleep disturbed? (circle): Yes No

24. How many hours a night do you usually sleep? _____

25. Are you troubled by your heart pounding or by shortness of breath? (circle): Yes No

26. Taking everything into consideration, how would you describe your satisfaction with life in general at the present moment? (circle):

Excellent Good Fair Poor

27. How would you rate your mental or emotional health at the present time? (circle):
Excellent Good Fair Poor

28. Compared to one year ago, how would you rate your mental or emotional health? (circle):
Better About the same Worse

29. How well do you use the telephone? (circle):

Without help With some help Unable to use telephone

30. Do you cook meals for yourself? (circle):

Without help With some help Unable to cook meals

31. Do you handle your own money? (circle):

Without help (write checks, pay bills, etc)

With some help (manage day to day budgeting, but need help managing checkbook and paying bills)

I do not handle my own money

35. Are you able to feed yourself? (circle):

Without help (able to feed yourself completely)

With some help (need help cutting meat, etc)

I am not able to feed myself

36. Do you dress and undress yourself? (circle):

Without help (able to select clothes, dress, and undress)

With some help

I am not able to dress myself

37. Do you take care of your own appearance? For example: combing your hair or shaving (circle):

Without help

With some help

I am unable to take care of my appearance

38. How do you get in and out of bed? (circle):

Without any help or aids

With some help (either from a person or with the aid of a device). Explain:

_____

_____

I am unable to get in and out of bed on my own

39. How do you bathe? (circle):

Without help

With some help (getting in and out of tub or shower or need special attachments). Explain:

_____

_____

40. Do you ever have trouble getting to the bathroom on time? (circle):

Yes No

41. How often do you wet or soil yourself? (circle):

Once or twice a week

Three times a week

Never

42. Have there been any recent changes in care needs? (circle):

    Yes No

    If yes, please describe:

    _____

    _____

43. During the past six months, have you had any help with things such as shopping, cooking, taking medications, housework, bathing, dressing, and getting around? (circle): Yes No

    If yes, who is your major helper?

    _____
    Name

    _____
    Relationship to Applicant

44. Are you receiving any assistance from an outside agency, such as Home Health? (circle):

    Yes No

    If yes, what agency?

    _____

45. Do you have any concerns about living in an assisted living facility? (circle): Yes No
    If yes, please describe.

    _____

    _____

    _____

    _____

46. Is religion important in your life? (circle): Yes No

47. Do you have any religious beliefs potentially impacting your care? (circle): Yes No

If yes, how often do you attend services and where?

_____

_____

48. Is there anything else you would like us to know about your physical, mental, emotional, or spiritual health?

_____
_____
_____

_____

DAILY RATE/ROOM AND BOARD INFORMATION

Those who receive ACCS or ERC Medicaid financial assist will be charged according to the Room and Board rules set by the Economic Services Division of the State of Vermont.

The Private daily rate is a set amount per day. A tier worksheet is used to determine if an additional amount will be charged per month. This worksheet is done from an assessment of a resident's care needs. This will be updated at least annually.

Our facility may have some rates dependent on size of the room.

Cost of cable service and telephone are not included in the daily rate or room and board charge.

For more details, please speak with our Administrator.

FINANCIAL/INSURANCE INFORMATION

1. Do you have a bank trust department or other agent who manages your financial affairs? (circle): Yes No If yes, please provide:

_____
Name

_____

_____
Address

_____
Relationship to Applicant

2. Have you assigned a Power of Attorney*? (circle): Yes No

If yes, please provide:

_____
Name

_____

_____
Address

_____
Phone #

_____
Relationship to Applicant

*Please provide a copy of this document

3. Health Insurance:

Medicaid Number: _____

Medicare Number: _____

Medicare Part (circle): A B D

4. Do you have long term care insurance? (circle): Yes No

If yes, please provide:

_____
Name of Company

_____

_____
Address

_____
Phone #

_____
Policy #

5. Do you have any other health, accident, or income protection insurance?
   (circle): Yes No

   If yes, please provide:

   _____
   Name of Company

   _____

   _____

   Address

   _____
   Phone #

   _____
   Policy #

FINANCIAL STATEMENT

Please provide accurate, honest, and complete information. This information will be kept strictly confidential.

Monthly Income/Assets:

1. Social Security: $_____
2. Retirement/Pension: $_____
3. Rental Income: $_____
4. Annuities/Investments: $_____
5. Other Income: $_____
6. Do you own your own home? (circle): Yes No

If yes, approximate value: $_____

7. Value of other real estate assets: $_____
8. Value of other assets: $_____

Method of Payment (circle all that apply):

Private Pay Private Insurance SSI Choices for Care

Other: _____

If you circled “private pay”, how long will you be able to agree to private pay? (circle):

7-12 months *13-24 months* 25-36 months* 36-48 months 49+ months

*Choices for Care eligibility is determined by the State of Vermont, Medicaid Waiver Program eligibility and availability cannot be predicted or guaranteed

POLICIES

Pets:
Ethan Allen Residence does not allow pets to reside in the Residence. Animals are welcome to visit at any time once appropriate vaccination records are provided.

Personal motor vehicles:
Personal motor vehicle policies vary by location. Please confer with the Residence's admissions contact for more information.

Smoking:
Smoking policies vary by location. Please confer with the Residence's admissions contact for more information.

Discharge:
It is the philosophy of Ethan Allen Residence for residents to remain at the Residence through end of life. However, there may be circumstances that do not allow this for the safety of residents and staff.

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Dear Sir and/or Madam,

The person identified on the attached form has applied for residence, or is being reevaluated for continued residency, at Ethan Allen Residence, a Level III residential care facility. In order to determine his/her suitability and eligibility for residence, and to determine services required, we will need the information requested on the attached form. With respect to financial information, we may verify income and assets of potential and/or current residents.

To comply with these requirements, we ask your cooperation in supplying the information requested on the attached form for the person identified below. This information will be held in strict confidence for use only for the purposes described above.

Thank you for your consideration.

Sincerely,

Shannon Robtoy
Administrator

RELEASE FORM

Name of Applicant: _____ Date: _____

Current Mailing Address:

_____
Street Address Apt/Suite

_____
City State Zip Code

Legal Address (if different from mailing address):

_____
Street Address Apt/Suite

_____
City State Zip Code

Social Security Number (SSN): _____ - _____ - _____

I hereby authorize Ethan Allen Residence, and its agents, to contact any individuals, Social Security, agencies, offices, groups, or organizations to obtain any information or materials deemed necessary to verify my suitability of eligibility for residence and services which I may require. I further authorize any of those contacted to release the information requested to Ethan Allen Residence and its agents.

The information on this form is to be used by Ethan Allen Residence and its agents to assist in determining the eligibility and suitability of the applicant for residency at Ethan Allen Residence and identify appropriate services. We may be required to share financial and/or medical information with authorized state or federal entities upon written request.

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

If a legally authorized representative has signed on behalf of the applicant, please attached documentary evidence indicating the extent and nature of this legal authorization.

Ethan Allen Residence
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1200 North Avenue,
Burlington, VT 05408 p
802-658-1573
f 802-497-1597
ethanallen@livingwellgroup.org

CONFIDENTIAL MEDICAL INFORMATION RELEASE AUTHORIZATION

To: _____
Name of Physician or other person(s) receiving release authorization

Address

_____

_____

_____ _____
Phone Fax

I hereby authorize you to release to Ethan Allen Residence any information including diagnosis, medical records, treatments or examinations rendered to me while under your care.

_____ _____
Patient Name Date of Birth

_____
Signature of Patient or Person Authorized for Consent for Patient

_____ Date

If Consenter used, please print name, address, and phone number:

_____

_____

Confidentiality Notice

This document contains PRIVILEGED and CONFIDENTIAL information intended only for the use of the addressee(s) named above. If you have received this document in error, you are requested to destroy all documents. Thank you.