



Select Which Home You Are Interested In:

**Loretto Home**  
59 Meadow Street  
Rutland, VT 05701  
802-773-8840

**St. Joseph Residential Care Home**  
243 North Prospect Street  
Burlington, VT 05401  
802-864-0264

**St. Joseph Kervick Residence**  
131 Convent Avenue  
Rutland, VT 05701  
802-775-5133

**Michaud Memorial Manor**  
47 Herrick Road  
Derby Line, VT 05830  
802-873-3152

Name: \_\_\_\_\_

Current address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Gender:  Male  Female

Social security number: (                    )

Marital status:  Single  Widowed  Married  Divorced

Religious Affiliation: \_\_\_\_\_

Are you an Armed Services Veteran?  Yes  No

Name/address of responsible party: \_\_\_\_\_

Relationship to applicant:  POA (attach documents)  Guardian (attach documents)  Family  
 Friend  Other: \_\_\_\_\_

Telephone number for individual listed above (responsible party):

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-mail address for individual listed above (responsible party): \_\_\_\_\_

Preferred date of admission: \_\_\_\_\_

Why would you like to be considered for admission to this home? \_\_\_\_\_

\_\_\_\_\_

Primary Physician: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Will this physician be retained during your residence at the home?  Yes  No

What other doctors do you see? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### General Information

Have you completed an advance directive for health care or a living will?

Advance directive:  Yes  No

Living will:  Yes  No

DNR  Full Code  COLST (Attach supporting documentation)

If you have not completed a COLST form with your physician, please make arrangements to do so prior to admission.

Do you currently drive a vehicle that you would be bringing with you?  Yes  No

If yes, please provide...

Make/Model: \_\_\_\_\_

Plate number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

State of registration: \_\_\_\_\_

Driver's license: \_\_\_\_\_

Do you have pre-planned funeral arrangements?

If yes, please provide...

Name of funeral home: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Yes  No

Address: \_\_\_\_\_

Are you currently working with a case manager or case worker?

Have you in the past 3-5 years?

If yes, please provide...

Name of case worker: \_\_\_\_\_

Address: \_\_\_\_\_

Yes  No

Yes  No

Agency or Hospital: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Type of service:  Medical  Financial  Other

## Functional and Health Information

1. During the last six months, how many times have you seen your doctor or primary physician? \_\_\_\_\_

2. How many days in the last six months were you in the hospital for health related problems? \_\_\_\_\_

What sort of health problems were you hospitalized for? \_\_\_\_\_

3. How would you rate your overall health at the present time?  Excellent  Good  Fair  Poor

4. Do you have periods of confusion or forgetfulness that interfere with your daily activities?  Yes  No

5. Do you need assistance taking your medicine?  Yes  No

If yes, please describe the assistance needed: \_\_\_\_\_

6. Are you allergic to any medications?  Yes  No

If yes, What are you allergic to? \_\_\_\_\_

The reaction you experience: \_\_\_\_\_

7. How do you walk? (Alone, with a cane or walker, etc.) \_\_\_\_\_

8. Do you have difficulty keeping your balance while walking?  Yes  No

9. Do you use any of the following?  Dentures  Hearing Aids  Wheelchair

10. How is your eyesight? \_\_\_\_\_

11. Do you drink alcohol?  Yes  No \*We are an alcohol-free facility unless prescribed by a physician.

12. Do you use tobacco products?  Yes  No \*We are a smoke free facility.

13. Do you have a history of drug or alcohol dependency?  Yes  No

14. Have you ever been convicted of a crime or violation other than a minor traffic infraction?  Yes  No

If yes, please explain: \_\_\_\_\_

15. Do you have any physical problems or illnesses at the present time that seriously affect your health?

Yes  No

If yes, please explain: \_\_\_\_\_

16. Do you feel that you need medical care or treatment beyond what you are receiving at this time?

If yes, please explain: \_\_\_\_\_

17. Do you have any skin conditions or open wounds?  Yes  No

18. How would you rate your mental or emotional health at the present time?

Excellent  Good  Fair  Poor

Please explain: \_\_\_\_\_

19. Do you see a mental health care provider?  Yes  No  
Have you in the past 3-5 years?  Yes  No

20. How do you manage your meals?

Without help (able to feed myself completely)  
 With moderate help (need help cutting meat, etc.)  
 With total help

21. Do you take care of your own grooming?  Yes  No

If no, please specify how you need help with grooming: \_\_\_\_\_

22. Do you take a  Shower  Bath

Without help  
 With some help (need help getting in and out of the tub, need special equipment on the tub, etc)  
Please explain: \_\_\_\_\_  
 With total help

23. Do you ever have trouble getting to the bathroom in time?

No, Never  
 Yes  
 Incontinence briefs  
 Have a catheter or colostomy

24. During the last six months, have you had any help with: shopping, cooking, taking medications, housework, bathing, dressing or getting around?  Yes  No

If yes, how often? \_\_\_\_\_

### Dietary Information

Do you have any dietary restrictions?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you allergic to any foods?  Yes  No

If yes specify: \_\_\_\_\_

The reaction experienced? \_\_\_\_\_

Are you on a specialized diet?  Yes  No

Do you have difficulty chewing or swallowing?  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Business Information**

Do you handle your own business affairs?  Yes  No

If no, please provide information explaining who handles this:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Relationship to applicant:  POA  Guardian  Rep. Payee  Attorney  Family  Friend

Do you have a bank trust department or agent who manages your financial analysis?  Yes  No

If yes, please provide the trustee or agent's...

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Ext. \_\_\_\_\_

Relationship to applicant:  POA  Guardian  Rep. Payee  Attorney  Family  Friend

Health insurance (upon admission, provide copies of insurance cards)

Do you have Medicare? If yes, please provide number.  Yes  No

Medicare Part A (Hospital) monthly premium

Medicare Part B (Physician) deducted from social security

Medicare part D (Prescription) co-pay amount

Number: \_\_\_\_\_

Do you have Medicaid? If yes, please provide number:  Yes  No

Number: \_\_\_\_\_

Attach copy of Medicaid Application:

Green Mountain Care/Community Medicaid  LTC/CFC Medicaid  Active  Pending

Health, Accident, Private LTC or Income Protection Insurance?  Yes  No

If yes, please provide...

Name of company: \_\_\_\_\_ Address: \_\_\_\_\_

Policy number monthly premium: \_\_\_\_\_ Brief description: \_\_\_\_\_

If you have more than one policy, please use additional space below:

Name of company: \_\_\_\_\_ Address: \_\_\_\_\_

Policy number monthly premium: \_\_\_\_\_ Brief description: \_\_\_\_\_

Name of company: \_\_\_\_\_ Address: \_\_\_\_\_

Policy number monthly premium: \_\_\_\_\_ Brief description: \_\_\_\_\_

Prescription drug coverage?  Yes  No

If yes, please provide...

Name of company: \_\_\_\_\_ Address: \_\_\_\_\_

Policy number monthly premium: \_\_\_\_\_ Brief description: \_\_\_\_\_

Financial information

A. Income: List all income from all sources, including, but not limited to:

Source	Amount Received	How Often	Name and Address to Verify
Wage/Salary			
State Assistance (3 Squares Fuel Assistance, Etc.)			
Social Security			
Veteran Pension			
Disability (SSDI)			
Interest			
Alimony			
Annuities			
Dividends			
Rental Income			
Other			
Other			

How many people live on your income? \_\_\_\_\_

B. Assets: List all bank accounts, including savings and checking, stocks and bonds, CDs, cash value of life insurance and other assets, excluding real estate

Type	Name of Owner and Co-owner	Name of Bank, Credit Union or Other Financial Institution	Account Number	Balance or Value
Savings Account				
Savings Account				
Checking Account				
Checking Account				
Christmas Club				
IRA, KEOUGH, 401K				
Savings Bond or Trust				
Certificate or Deposit (CD)				
Pension/Retirement				
Other				

C. Real Estate: List of all Real Estate in which you have ownership interest:

Type, Address of property	Fair Market Value	Mortgage Holder	Mortgage Balance

D. Other expenses: List all expenses you pay on regular basis:

Rent/Mortgage	\$	Real Estate	\$	Real Estate Taxes	\$
Telephone	\$	Car Payment	\$	Car Insurance	\$
Credit Card	\$	Fuel	\$	Automobile Fuel	\$
Pharmacy	\$	Electricity	\$	Life Insurance	\$
Personal Loan	\$	Other	\$	Other	\$

E. Do you anticipate any changes in income and assets (including real estate Ownership) within the next twelve months  Yes  No

If yes, please explain: \_\_\_\_\_

F. Have you or your spouse given away, sold, or traded anything in the Last 60 months (5 years)?

First Name: Initial	Item Sold/ Traded/Gifted	Date of Transaction

G. Have you or your spouse added another person's name to any assets such as financial accounts or property in the last 60 months (5 years?)

First Name: Initial	Asset	Date of Transaction

Have you or your spouse placed any assets in a trust in the last 60 months (5 years)?

First Name: Initial	Asset Placed in Trust	Date of Transaction

I. State any other information which you think is helpful in processing this application:

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**DISCLOSURE:**

Information on this form may be used by the Vermont Catholic Charities Residential Care Home and its agents to assist in determining the eligibility and suitability for residency at the Vermont Catholic Charities Residential Care Home and in determining which services may be required by our funding sources to document the eligibility of the residents. For this reason, financial information on this form may be disclosed to these funding sources without further notice to the applicant. By law, the Vermont Department of Aging and Disabilities is entitled to residents' medical and health records for the purpose of licensing and certification. Pursuant to 18 V.S.A Chapter 113, Section 5286, it is the policy of the Vermont Catholic Charities Residential Care Home whose name is listed on this Application for Residence to prohibit physicians from prescribing or providing a dose(s) of medication(s) intended to be lethal for a patient who is a resident in or admitted to this Residential Care Home and intended for use on this Residential care Home's premises. The undersigned agrees and understands that terminating the Life of the resident indicated in this Application for Residence on this Residential Care Home's premises by use of a physician prescription for a dose(s) of medication(s) Intended to be lethal is prohibited.



**Statement of applicant or legally authorized representative**

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

Signature of Applicant:

\_\_\_\_\_

Date: \_\_\_\_\_

Signature of Legal Representative:

\_\_\_\_\_

Date: \_\_\_\_\_

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

# Medical Information Release Form

Resident Name: \_\_\_\_\_

DOB: \_\_\_\_\_

This signed medical information release form authorizes the release to \_\_\_\_\_ of any medical information they request from any physician, hospital, clinic, or nursing home to whom I am or have been known.

This authorization includes psychiatric history and treatment, as well as any other form of medical treatment, and history of care received.

Please send ASAP:

- COLST Form
- 6 Months progress notes and any other medical treatments (labs, therapy, etc.)
- Problem List
- Medication List
- Health & Physical

Resident Signature (or Legal Representative): \_\_\_\_\_

Witness signature: \_\_\_\_\_

Date: \_\_\_\_\_

Medical Provider: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_