Vermont Catholic Charities

Select Which Home You Are Interested In:

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

☐ **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

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
f yes, please provide...
Make/Model: _____ State of registration:_____
Plate number:_____ Driver's license:_____
Expiration Date:_____

Do you have pre-planned funeral arrangements? ☐ Yes ☐ No
If yes, please provide...
Name of funeral home:_____ Address:_____
Telephone number:_____ _____

Are you currently working with a case manager or case worker? ☐ Yes ☐ No

Have you in the past 3-5 years? ☐ Yes ☐ No

If yes, please provide...
Name of case worker:_____ Agency or Hospital:_____
Address:_____ 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?
☐ 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:_____ Policy #:_____
Monthly Premium: _____ Brief description:_____

If you have more than one policy, please use additional space below:
Name of company:_____ Policy #:_____
Monthly Premium: _____ Brief description:_____

Name of company:_____ Policy #:_____
Monthly premium: _____ Brief description:_____

Prescription drug coverage? ☐ Yes ☐ No
If yes, please provide…
Name of company:_____ Policy #:_____
Monthly premium: _____ Brief description:_____

Financal 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:

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 Respresentative: _____

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:_____