Living Well Residence
a Living Well Community

Introduction

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 Living Well Residence, 71 Maple Street, Bristol, VT 05443

- 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 802.453.3946

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71 Maple Street
Bristol, VT 05443
802.453.3946
https://livingwellgroup.org

YOUR NAME_____

CURRENT ADDRESS: _____

_____

EMAIL ADDRESS: _____

PHONE #: _____ CELL PHONE #:_____

DATE OF BIRTH: _____ BIRTHPLACE_____

SEX: (Circle) M F

SOCIAL SECURITY #:_____

MARITAL STATUS: (Circle) MARRIED SINGLE WIDOWED DIVORCED

DO YOU HAVE ANY RELIGIOUS BELIEFS AFFECTING YOUR CARE:_____

NAME OF NEAREST RELATIVE OR RESPONSIBLE PERSON:

_____

RELATION: _____

ADDRESS: _____

_____

PHONE #: _____ CELL PHONE #:_____

WORK PHONE #: _____

E-MAIL_____

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Application for Residency

I. GENERAL INFORMATION

1. Primary Physician: _____
   Phone #: _____

2. Will this physician be retained during your residence?
   (Circle) Yes No

3. Do you handle your own business affairs? (Circle) Yes No

4. If no, who handles these affairs?

   Name: _____ Phone #:_____
   Address: _____
   Relationship to Applicant: _____

5. Why would you like to be considered for admission to Living Well Residence?
_____
_____

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

7. What are your interests/hobbies? _____
_____

8. Living Well Residence does not allow pets or personal motor vehicles to stay here (animals are welcome to visit at any time, once appropriate vaccination records are provided).

Living Well Residence is a non-smoking facility

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II. FUNCTIONAL ASSESSMENT

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

2. During the past six months, how many days were you so sick that you were unable to carry on your usual activities?
(Circle one): None A week or less More than a week

3. How many days in the past six months were you in a hospital for health issues?
_____

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

_____

5. How would you rate your overall health at the present time?
(Circle one): Excellent Good Fair Poor

6. How would you rate your overall health compared to a year ago?
(Circle one): Better About the same Worse

7. How much do your health issues stand in the way of your doing the things you want to do?
(Circle one): Not at all A little A great deal

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

9. Please describe current health issues? _____

_____

_____

_____

10. How do these issues affect your day-to-day life?_____

_____

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11. Please list your medications including dosages and time of day. Include supplements and over-the-counter medications as well.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

13. Do you need assistance taking your medications? Yes No

If yes, describe: _____

_____

14. Are you allergic to any medications or foods? Please specify any reaction you have experienced _____

15. Do you have any dietary restrictions (no salt, sugar, etc.)?

Yes No If yes, explain: _____

_____

16. Do you have any difficulty eating? Yes No

If yes, explain: _____

_____

17. Do you use any of the following aids? (Circle, if applicable):

Wheelchair Cane Walker Glasses Dentures Hearing Aid

Other: _____

18. How is your eyesight? (Circle one): Excellent Good Fair

Poor Totally Blind Wear Glasses Wear Contact Lenses

19. Have you ever had a drinking problem or has your doctor ever advised you to cut down on drinking? Yes No

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20. Do you use tobacco products including chewing tobacco? (Circle one):
Yes No

21. Do you feel that you need medical care or treatment beyond what you are receiving at this time? Yes No

If yes, explain: _____

_____

22. How well do you walk? (Circle one):

Alone Alone with a cane, walker, etc.

Can walk only with the help of a person Cannot walk

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

24. Is your sleep disturbed? Yes No

25. How many hours each night do you sleep usually? _____

26. Are you troubled by your heart pounding or by shortness of breath?
Yes No

27. Taking everything into consideration, how would you describe your satisfaction with life in general at the present time?
(Circle one): Excellent Good Fair Poor

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

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

30. Do you use the telephone?
(Circle one): Without help With some help Unable to use telephone

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31. Do you cook meals for yourself?
(Circle one): Without help With some help Unable to cook meals

32. Do you handle your own money?

A. Without help (write checks, pay bills, etc.).

B. With some help (manage day-to-day buying, but need help with managing the checkbook and paying your bills).

C. I don't handle my own money.

33. Ability to feed self?

A. Without help (able to feed yourself completely)

B. With some help (need help cutting meat, etc.)

C. With total help

34. Do you dress and undress yourself?

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

B. With some help.

C. With total help.

35. Do you take care of your own appearance? For example: combing your hair and/or (for men) shaving.

A. Without help.

B. With some help.

C. With total help.

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36. How do you get in and out of bed?

A. Without any help or aids.

B. With some help (either from a person or with the aid of some device). If device, explain: _____

_____

C. With total help.

37. Do you take a (Please circle) Bath (or) Shower

A. Without help.

B. With some help (need help getting in and out of tub, or need special attachments on the tub). Please explain:

_____

C. With total help.

38. Do you ever have trouble getting to the bathroom on time?

A. No, never.

B. Yes, sometimes.

39. How often do you wet or soil yourself (either day or night)?

A. Once or twice a week.

B. Three times a week or more (use pads or briefs?)

C. Never.

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40. Have there been any recent changes in care needs?
Yes____ No____ If yes explain_____

_____

41. During the past six months, have you had any help with such things as shopping, cooking, taking medications, housework, bathing, dressing, and getting around?

A. Yes

B. No

42. If you answered "yes" to Question 40 above, who is your major helper?
Name: _____

Relationship: _____

43. If receiving any assist from outside agencies such as Home Health.
What is the name of the agency?_____

44. Mental Status issues. (Check all that apply)

Confusion___ Forgetfulness___ Difficulty expressing self___

Wandering___ in/out doors ____ Sociable___ Withdrawn ____

Depression___ Anxiety___

45. Do you have any concerns about living in an assisted living facility?

Yes___ No___ If yes, explain _____

_____

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46. Is religion important in your life?_____

Attend church services weekly? ____ If so where?_____

47. Is there any other information you feel is important for us to know about you?

_____

_____

_____

_____

_____

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Daily Rate/Room and Board

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.

Some of our facilities may have some rates dependent on size of the room, please inquire.

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 House Manager.

General Information

1. Name: _____ Birth date: _____

2. Do you have a bank trust department or other agent who manages your financial affairs? (Circle one): Yes No

   If yes, please provide: Name: _____

   Address: _____

   Relationship: _____

3. Have you assigned a Power of Attorney?* (Circle one): Yes No
   If Yes, please provide

   Name: _____

   Address: _____
   Relationship: _____Phone #: _____

   *We will need a copy of this document.

4. Health Insurance

   Medicaid Number: _____

   Medicare Number: _____

   Do you have*Medicare Part A? (Circle one): Yes No

   Medicare Part B? (Circle one): Yes No

   Medicare Part D? (Circle one): Yes No

*We will need copies of these cards

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5. Other health, accident or income protection insurance*? Yes No
If yes, Name of Company: _____

Address: _____

Policy #: _____ Brief Description: _____

_____

*We will need a copy of this card.

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Financial Statement

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

Name: _____
Social Security #:_____ Date of Birth:_____
Address: _____ City, State, Zip _____

Responsible Party (Individual responsible for paying bills, POA, Self, Other)

Name: _____
Address:_____ City, State, Zip _____
Phone: (H) _____ (W)_____ (C)_____
Relationship to Resident: _____
Email:_____

Income/Assets
Social Security $_____
Retirement/Pension $_____
Rental Income $_____
Other Income $_____
Annuities/Investments $_____

Do you own your own home? Yes ____ No ____
If yes, approximate Value $_____
Value of other real estate assets: $_____
Value of other assets $_____

Method of Payment (please check all that apply)

Private Pay ___ Private Insurance ____ SSI ___ Choices for Care ___Other _____

If Private Pay, how long do you anticipate being private pay?
0-6 months* _____ 7-12 months*_____ 13-24 months*_____
25-36 months _____ 36-48 months _____ 49 + months _____

Have you applied, or will be applying, for State Medicaid Assistance (Choices for Care*)?
Yes ____No ____

*Choices for Care eligibility is determined by the State of Vermont, Medicaid Waiver Program eligibility and availability cannot be predicted nor guaranteed

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Living Well Residence

Dear Sir and/or Madam,

The person identified on the attached form has applied for residence, or is being re-evaluated for continued residency, at Living Well, 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,

Jeana Lavallee
House Manager
Living Well Residence

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RELEASE FORM

DATE: _____

INQUIRY IN REFERENCE TO NAME: _____

MAILING ADDRESS: _____

LEGAL ADDRESS: _____

SOCIAL SECURITY #: _____

I hereby authorize Living Well 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 Living Well Residence and its agents.

The information on this form is to be used by Living Well Residence and its agents to assist in determining the eligibility and suitability of the applicant for residency at Living Well 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 attach documentary evidence indicating the extent and nature of this legal authorization.

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jlavallee@livingwellresidence.org

CONFIDENTIAL MEDICAL INFORMATION RELEASE AUTHORIZATION

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

_____
Address

_____
City, State, Zip Code

_____
Phone Fax

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

_____ _____
Patient Name Date of Birth

_____
Physician

_____ _____
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.