



# Ethan Allen 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

Mary Mougey, Administrator  
1200 North Avenue  
Burlington, VT 05408

or

[mmougey@livingwellgroup.org](mailto:mmougey@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 802-658-1573

## PERSONAL INFORMATION

**Full Name:** \_\_\_\_\_  
First Middle Last

**Preferred Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Place of Birth:** \_\_\_\_\_

**Sex:** \_\_\_\_\_

**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

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

**Relation:** \_\_\_\_\_

**Current Mailing Address:**

Street Address

Apt/Suite

City

State

Zip Code

**Email:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Work 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

Address

Phone #

Email

**3. Why would you like to be considered for admission to Ethan Allen Residence?**

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

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**5. What are your interest/hobbies?**

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**FUNCTIONAL ASSESSMENT**

**1. Please describe your current health issues:**

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**2. How do these issues impact your daily life?**

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

\_\_\_\_\_

**4. 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

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

**If yes, how many days were you hospitalized?:** \_\_\_\_\_

**6. What sort of health issues were you hospitalized for?:**

\_\_\_\_\_

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

Excellent          Good          Fair          Poor

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

Better          About the same          Worse

**9. 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

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

**11. Please circle all that apply to your mental status:**

Confused          Forgetful          Difficulty expressing self

Wandering          Sociable          Withdrawn          Depression

Anxiety

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

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\_\_\_\_\_

\_\_\_\_\_

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

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**14. Do you need assistance taking medications? (circle):** Yes                      No

**If yes, please describe:**

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**15. Are you allergic to any medications or foods? (circle):** Yes                      No

**If yes, please describe any reactions you have experienced:**

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**16. Do you have any dietary restrictions? (circle):** Yes                      No

**If yes, please describe:**

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

**If yes, please describe:**

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

Wheelchair      Cane      Walker      Glasses

Contact Lenses      Dentures      Hearing Aid

Other: \_\_\_\_\_

**19. How is your eyesight? (circle):**

Excellent      Good      Fair      Poor      Totally Blind

Other: \_\_\_\_\_

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

**21. Do you use tobacco/nicotine products including chewing tobacco? (circle):**

Yes      No

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

**23. 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:**

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**24. How well do you walk? (circle):**

Alone      Alone with a cane, walker, etc

Only with the help of another person      Cannot walk

**25. Do you have difficulty keeping your balance while walking? (circle):**

Yes                      No

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

**27. How many hours a night do you usually sleep?:** \_\_\_\_\_

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

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

Excellent                      Good                      Fair                      Poor

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

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

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

Without help                      With some help                      Unable to use telephone

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

Without help                      With some help                      Unable to cook meals

**34. 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:

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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:

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**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:**

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**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?**

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**45. Do you have any concerns about living in an assisted living facility? (circle):** Yes                      No

**If yes, please describe.**

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**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?**

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

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## 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 do you anticipate being private pay? (circle):**

0-6 months\*

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.

## **ETHAN ALLEN 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 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,

Mary Mougey  
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

a Living Well Community

1200 North Avenue  
Burlington, VT 05408

p 802-658-1573

f 802-497-1597

[mmougey@livingwellgroup.org](mailto:mmougey@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.