



328 School Street  
Enosburg Falls VT 05450  
802.933.2315 TEL  
802.933.7997 FAX  
[www.brownway.com](http://www.brownway.com)

## Admissions Application (Confidential)

APPLICANTS NAME \_\_\_\_\_ DATE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ MARITAL STATUS:  M  W  D  S

SOCIAL SECURITY NO. \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

MEDICARE NO. \_\_\_\_\_ MEDICAID NO. \_\_\_\_\_

Do you have Long Term Care Insurance?  Yes  No

Are you enrolled in the State of Vermont Choices for Care Program?  Yes  No

If yes, name of caseworker and agency: \_\_\_\_\_

Other Health Insurance Provider(s): \_\_\_\_\_

ID NO.(S) \_\_\_\_\_ PROVIDER NO.(S) \_\_\_\_\_ POLICY NO.(S) \_\_\_\_\_

Are you being admitted from home?  Yes  No

Do you have Home Health Services?  Yes  No

If yes, name of home health provider and organization: \_\_\_\_\_

NAME OF LEGAL FINANCIAL REPRESENTATIVE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE NO. \_\_\_\_\_

WORK PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

NAME OF LEGAL HEALTH CARE REPRESENTATIVE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE NO. \_\_\_\_\_

WORK PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

NAME OF POWER OF ATTORNEY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE NO. \_\_\_\_\_

WORK PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PHONE NO. \_\_\_\_\_ WORK PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

**Additional Contact Information** (children, relatives or friends involved in your care)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE NO. \_\_\_\_\_

WORK PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE NO. \_\_\_\_\_

WORK PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE NO. \_\_\_\_\_

WORK PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE NO. \_\_\_\_\_

WORK PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_

Do you have a Living Will or Advanced Care Directive? Yes No CPR or DNR

Do you have funeral arrangements made? Yes No

If yes, name of funeral home: \_\_\_\_\_

LOCATION \_\_\_\_\_ PHONE NO. \_\_\_\_\_

Do you have any food allergies? Yes No

If yes, please list: \_\_\_\_\_

Do you have any allergies to medications? Yes No

If yes, please list: \_\_\_\_\_

Do you have any dietary regulations? Yes No

If yes, please list: \_\_\_\_\_

Do you have any problems getting to the bathroom on time? Sometimes Never

Do you use any of the following: Wheelchair Walker Cane Glasses

Dentures: Upper Lower Both Hearing Aids: Left Right Both

Do you use alcohol? Yes No Do you use tobacco? Yes No

Do you need assistance getting in and out of bed? None Some assistance Total assistance

Do you assistance getting dressed? Yes No



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## Financial Information

*(Confidential)*

To assist with your financial planning during your stay at Brownway Residence, please complete the following:

Social Security	_____	Retirement/Pension	_____
	MONTHLY AMOUNT		MONTHLY AMOUNT
Supplemental Security Income (SSI)	_____	Annuities/Investments	_____
	MONTHLY AMOUNT		MONTHLY AMOUNT

### Real Estate Assets:

Do you own your home?       Yes    No    If yes, what is the approximate value \$ \_\_\_\_\_

Is the property co-owned?     Yes    No    If yes, what is the co-owners name \$ \_\_\_\_\_

Do you own additional property?    Yes    No    If yes, what is the approximate value \$ \_\_\_\_\_

### Life Insurance Cash Value:

Do you have life insurance policies with cash values?    Yes    No    If yes, cash value: \$ \_\_\_\_\_

### Cash Assets in Banks Credit Unions, Savings and Financial Institutions

INSTITUTION NAME	LOCATION
BALANCE	NAME(S) ON ACCOUNT
INSTITUTION NAME	LOCATION
BALANCE	NAME(S) ON ACCOUNT
INSTITUTION NAME	LOCATION
BALANCE	NAME(S) ON ACCOUNT

PRIVACY ACT STATEMENT: The information on this application is to be used by Brownway Residence to assist in determining eligibility and suitability of the applicant for residency at Brownway and services which may be required. The Vermont Department of Aging and Disabilities licenses Brownway Residence, and thus is entitled to access the resident's records for the purpose of licensing and certification. Appropriate authorization will be obtained from the applicant, or the applicants legally authorized representative, prior to release of information on this form to persons or entities other than the Department of Aging and Disabilities and Brownway Residence.