Applicants Name: ____ Date of Birth: ___________________

Mailing Address: ____

Marital Status: S □ D □ W □ M □ SSN#: ______________________________

Medicaid #: _____________________________ Medicare #: _________________________

Other Health Insurance Provider: ____

ID #: ______________________________ Provider #: ___________________________________

Policy #: ____

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: ____

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: ____

____

Contact Information:

Name of Legal Financial Representative: ___________________________Relationship: ______________

Address: ____

Home Phone #: _______________________________Work Phone #: ____________________________

Cell Phone #: ________________________________ Email: __________________________________

Name of Legal Health care Representative: _______________________Relationship: ______________

Address: ____

Home Phone #: _______________________________Work Phone #: ____________________________

Cell Phone #: ________________________________ Email: __________________________________

Name of Power of Attorney: _________________________Relationship: _____________________

Address: ____

Home Phone #: _______________________________Work Phone #: ____________________________

Cell Phone #: ________________________________ Email: __________________________________

Name of Emergency Contact: _________________________Relationship: _____________________

Address: ____

Home Phone #: _______________________________Work Phone #: ____________________________

Cell Phone #: ________________________________ Email: __________________________________

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

Name #1:____Relationship: _____________________

Address: ____

Home Phone #: _______________________________Work Phone #: ____________________________

Cell Phone #: ________________________________ Email: __________________________________

Name #2:____Relationship: _____________________

Address: ____

Home Phone #: _______________________________Work Phone #: ____________________________

Cell Phone #: ________________________________ Email: __________________________________

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

CPR □ **DNR** □

Do you have funeral arrangements made? Yes □ No □

If yes, name of funeral home: ________________________________Phone #: _____________________

Address: ____

Do you suffer from incontinence? Urine □ Bowel □ Both □

Do you currently have Dentures? Yes □ No □

Upper □ Lower □ Both □

Do you currently use Hearing Aids? Yes □ No □

Left □ Right □ Both □

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

Do you need assistance with transfers? (Ex: sitting to standing, in/out of bed)

Yes □ No □ Sometimes □

Do you need assistance getting dressed?

Yes □ No □ Sometimes □

Financial Information

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

(Per Month)

Social Security	$	Retirement/Pension	$
SSI	$	Annuities/Investments	$

Real Estate Assets

Do you own a 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 value? Yes □ No □

If yes, cash value is: $ ________________________

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

Name of Institution: _________________________________ Location:________________________

Balance: $__________________________________ Name on Account: ________________________

Name of Institution: _________________________________ Location:________________________

Balance: $__________________________________ Name on Account: ________________________

Name of Institution: _________________________________ Location:________________________

Balance: $__________________________________ Name 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 qualification. 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.