Applicants Name: _____ Date of Birth: _____

Preferred Name/ Nickname: _____ Maiden Name: _____

Mailing Address: _____

Primary Phone Number: _____ Email: _____

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

Religion: _____ Language: _____

Insurance | Payor Source Information:

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 □ Applying □

Where are you being admitted from? Home □ Rehab □ Hospital □
Other □ _____

Do you have Home Health Services? Yes □ No □
If yes, name of home health organization: _____

Are you enrolled in a Hospice program? Yes □ No □
If yes, name of Hospice organization: _____

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328 School Street
Enosburg Falls, VT 05450

(P) 802-933-2315
(F) 802-933-7997

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John Amanda St.Cyr
January 2022

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: _____

Medical Information:

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

DNR □ **CPR** □ If CPR, do you wish to discuss becoming a DNR? Yes □ No □

Please list all allergies (medications, insects, animals, food etc.) _____

_____

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Do you have funeral arrangements made? Yes □ No □
If yes, name of funeral home: _____Phone #: _____

Address: _____

Do you have the following, *please circle* : Burial Plot Headstone Urn

Are these arrangements irrevocable? Yes □ No □ Unknown □

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

Do you currently have Dentures? Both □ Upper □ Lower □ No □

Do you currently use Hearing Aids? Both □ Left □ Right □ No □

Do you wear glasses? Yes □ No □

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

Please circle which activities of daily living you need assistance with (even if it is only sometimes)

TRANSFER (SIT TO STAND ETC.) LOCOMOTION (WALKING, MOVEMENT) DRESSING (BUTTONS ETC.) EATING TOILETING BATHING

Assistive Devices: (please circle) Cane Walker Wheelchair Support Braces
Prosthesis: _____ Other: _____

Primary Care Provider Name: _____ Phone Number: _____

(Please circle the office you are seen at)

NOTCH: Richford, Enosburg, St. Albans, Swanton, Fairfax, Georgia NMC Primary Care St. Albans Primary Care

Cold Hollow Family Practice Northern Green Mtn. Medicine (formerly Dr. Corrigan)

Other: _____

Does Brownway Residence have permission to speak with your provider if we have any questions or need any forms signed confirming any health related information? *Please circle* YES | NO

Please list ALL medications - prescribed and over-the-counter: _____

Please list ALL of your (past and current) diagnosis: _____

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Income 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: $_____

Expenses:

Please list all monthly expenses (premiums and co-pays etc.) _____

Life Insurance:

Company Name: _____ Policy Number: _____

Do you have life insurance policies with cash value? Yes □ No □

If yes, cash value is: $ _____ Whole or Term Policy? _____

Surrender value: $

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: _____

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Other Information:

Please use this space to add any information you feel we should know. This could be any relevant questions, comments, extra health or financial information.

Please sign this application and return to Brownway Residential Care Home as soon as possible. It is crucial to get all requested documents to the facility for clinical and financial review. A review cannot be completed with missing information. *Financially*- Please note that the state of Vermont sends out an annual room and board calculator with guidelines that we must follow. Rent is depicted by the state, and you must make the minimum amount to be considered for placement. If you have questions please visit https://asd.vermont.gov/content/room-and-board-calculator-2022 or contact Brownway Residence for a copy of the letter. *Clinically* - Please note that there are also regulations that the facility must adhere to. If you are deemed a higher level of care than we can provide, the facility must deny admittance.

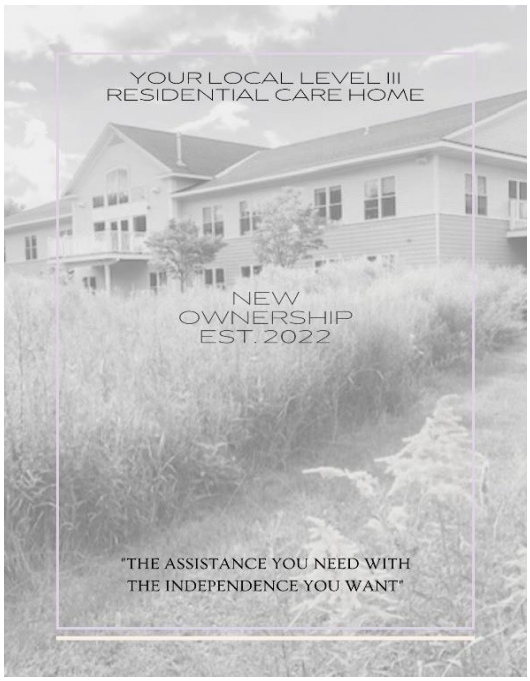
Signature of applicant or POA/Representative

Date

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.

Thank you for your interest in our facility. Signed,

John and Amanda St. Cyr



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