1 Pinnacle Meadows, Richford, VT 05476
802-848-7106, Fax: 802-848-3216, www.avemariacare.com, ldoe@avemariacare.com

Confidential Admission Application

Application date:__________ Admission date:__________

Name:________________________________ Date of birth:__________ Age:______ Religion:___________

Name of Primary Physician:__________________ Office Location:________________________

Physicians Phone: ______________ Physician's fax: ______________ Date of last exam:________________

Name and Location of the Pharmacy where you fill your prescriptions?________________________________

Marital Status: **M W D S** Place of Birth: _________________________ US Citizen? **YES / NO**

SSN:____________________ Medicare #:_____________________ Medicaid #: _____________________

Do you have Medicare Part A? **YES / NO**; Effective Date:_______ Medicare B?**YES / NO**; Eff.Date:_______

Do you have a Medicare D, Prescription Medication plan? **YES / NO** If yes, Effective Date: ____________

If yes, Plan name:_________________________ Plan Member ID #: _________________________

If no, do you have a plan that is the same or better than the Medicare D Plan? **YES / NO**

If yes, Plan name: (pension plan, Tri-care, teacher's retirement, etc…_________________________)

Are you enrolled in the State of Vermont, Choices for Care program: **YES / NO**

If Yes, Name of Case Worker and Agency:______________________________________

Do you have BC/BS 65 extended medigap policy? **YES / NO**

Other medigap health, accident? **YES / NO**

If yes, Name of Company:________________________Address:________________________________

Policy #:________________________________Description:____________________________________

Admitted from: _____________________Previous address: Box or street #________________________

City:_____________________State:______________Zip:____________ Phone:____________________

If admitted from home, have your been receiving Home Health Services? **YES / NO**

If yes, Name of Home Health Provider & Organization:____

Legal Guardian/Power of Attorney:_________________________________ Relationship:_____________

Address:____

Phone:___________________ Cell Phone:___________________ E-Mail:__________________________

Circle applicable authorization: Court Appointed Guardian; POA for Health Care; POA for Finances

Name of other Responsible Person:_________________________________ Relationship:_______________

Address:____

Phone:____________________ Cell Phone:___________________ E-Mail:__________________________

Circle applicable authorization: Court Appointed Guardian; POA for Health Care; POA for Finances

Provide contact info for children and also list any relatives or friends involved with your well-being:

Name:________________________Relationship:________Phone:____________Cell Phone:_____________

Address:____ E-Mail:____________________

Name:________________________Relationship:________Phone:____________Cell Phone:_____________

Address:____ E-Mail:____________________

Do you have a Living Will or Advanced Directive? **YES / NO**

Are you aware of the VT Advanced Directive Registry **YES / NO**

If yes, have you registered your Advanced Directive? **YES / NO**

Do you have a Do Not Resuscitate (DNR) Order in place? **YES / NO**

Funeral Arrangements? **YES / NO**; If yes, name of Funeral Home?__________________________________

How many times in the past year were you hospitalized?____________________ Dates:_________________

What were you hospitalized for?____

Most recent vaccinations: Flu _________ Pneumovac________ Tetanus __________ Tdap__________

Past Occupation: ____________________ Hobbies/Interests:_______________________________________

Highest Grade of School Completed? ____

Did You Serve in the Military? **YES/NO** Years of Service?______________________

Allergies to Food? **YES / NO** Please list:____

Environmental Allergies: **YES/NO** Please list: ____

Allergies to Medication? **YES / NO**: Please list____

List known reactions to medications above: ____

Do you have trouble getting to the bathroom on time? **Never** **Sometimes** **Have a catheter or colostomy**

Do you need assistance taking your medicine? **YES / NO** if yes please describe:_________________________

____

Do you have any diet restrictions (no salt, sugar, etc.) **YES / NO** if yes please explain_____________________

____

Do you have difficulty eating? **YES / NO** if yes please explain____

____

Height ______________ Weight ______________

Do you use any of the following aids: (circle if applicable)

Wheelchair **Cane** **Walker** **Glasses** **Dentures** upper lower **Hearing Aides** R L Both

Prosthetics Please list: ____

How is your eyesight? (circle) **Excellent** **Good** **Fair** **Poor** **Blind** Date of last exam: _______________

How often do you consume alcohol? ________________ Do you use tobacco products? **YES / NO**

If yes, what types and how often? _______________________________________

Do you have difficulty keeping your balance while walking? **YES / NO**

Have you received any physical therapy in the last 6 months? **YES/NO** If yes, where? __________________

Do you get in and out of bed: **Without help** **With some help** **With total help**

Do you need help getting dressed? **YES / NO**? Do you have nightmares or disturbed sleep? **YES / NO**

Do you have periods of confusion or forgetfulness that interfere with your daily activities? **YES / NO**

Please describe:____

____

Please describe any obsessive/compulsive behavior:____

____

Please describe any physically or verbally abusive behavior:____

____

____

Please describe inappropriate sexual behavior in applicant's prior history and/or since onset of dementia/illness:

____

____

Have you been diagnosed with Alzheimer's Disease or another form of Dementia? **YES / NO**:

If yes, when were you diagnosed and by whom? ____

Please describe incidents and frequency of wandering: ____

____

Have you consulted with the Memory Center, FAHC, Burlington? **YES / NO**

Have you ever received any mental health services? **YES/NO**

If yes, where and when? ____

Other than your primary physician listed on the front of the application, do you have other health care providers? Dentist:_______________Phone:_______________ Date of last exam: ___________________

Eye Doctor:_________________ Phone: __________________ Date of last exam: ___________________

Specialists of any kind (please include names and dates of service) ________________________________

*If Your Resident needs any Over-the-Counter items like Body Lotion, Protective Underwear, or Poise Pads, Would you like us to order these items from the Richford Pharmacy? YES / NO

I state that the information above is correct and true.

Signature: __________________________________Date:________________

Print Name: __________________________________

(If resident is unable to sign)
Signature of Guardian/POA: _____________________________________Date:________________

Print Name: ___________________________________

Representative of Ave Maria Community Care Homes, Inc

Admitted by: ______________________________Date:_________________

In order to help you with financial planning during your stay with us and to help determine if you are eligible for long term care programs please complete the following:

Does prospective resident have Long Term Care insurance providing benefits for room & board at a Residential Care/Assisted Living home? **YES / NO**

If yes, Name of Company:_________________Address:________________________________

Policy #:___________________Description:____

Monthly income:

Has the prospective resident applied, or will they be applying shortly for State Medical assistance (such as Medicaid)? **YES / NO** Medical Assistance/Medicaid #______________
Date of application________________, Where (County)?_________________

Social Security ________________________________(Monthly amount)$__________
Supplemental Security Income (SSI)________________(Monthly amount)$__________
Retirement/Pension ____________________________(Monthly amount)$__________
Rental Income ________________________________(Monthly amount)$__________
Annuities/Investments __________________________(Monthly amount)$__________

Real Estate Assets:
Does prospective resident own home? **YES / NO** Approximate value $_____________
Property co-owned? **YES / NO** Name of co-owners _______________________
____

Any additional property?______________________Approximate value $______________

Life insurance cash value:

Does prospective resident have life insurance policies with cash value? **YES / NO**

If yes, approximate value____________________________________$______________

Cash assets in banks, credit unions, savings, brokerage, and financial institutions:

Institution name:______________________Location_____________________________

Balance______________________________Names on account______________________

Institution name:______________________Location_____________________________

Balance______________________________Names on account______________________

Institution name:______________________Location_____________________________

Balance______________________________Names on account______________________

I state that the above information is true and correct:

Print Name____________________________

Signature______________________________Date_________________

Name of Power of Attorney (POA)______________________________

Signature______________________________Date_________________

Ave Maria CCH, Inc. holds all resident financial information strictly confidential and will not release any personal financial information without approval of the resident, their designated guardian or power of attorney.