Ave Maria
Community Care Homes, Inc.™
Dedicated to Caring

1 Pinnacle Meadows, Richford, VT 05476
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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?_____

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

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

List known reactions to medications above: _____

Do you take Over the Counter Supplements? (i.e. Fish Oil, Garlic, Vitamin D, St. John's Wort, etc.) **YES / NO**

If **YES**, please list as space is limited _____

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

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

Do you wear Protective Underwear or Poise Pads Daily? **YES / NO**

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

Are you on a special diet or have any diet restrictions? (i.e. Gluten Free, Lactose Free, pureed meals, thickened drinks, Diabetic, Diverticulitis, No Salt, No Sugar, etc.) **YES / NO**

If **YES,** please describe:_____

Are you treated for Diabetes? **YES/NO**, If yes, circle one: Type 1 or Type 2; Do you have insulin-dependent Diabetes? **YES/NO**

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

An Admission Fee of $500.00 is due with the application. If the resident is on a Medicaid program the Admission Fee may be waived. The Admission Fee is refunded if the resident is not admitted.

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.