The Gary Residence
RESIDENTIAL CARE | MEMORY CARE

149 Main Street, Montpelier, VT 05602
TEL: 802-223-3881 – FAX: 802-223-4468

Westview Meadows
INDEPENDENT LIVING | RESIDENTIAL CARE

171 Westview Meadows Road, Montpelier, VT 05602
TEL: 802-223-1068 – FAX: 802-223-3233

CONFIDENTIAL APPLICATION FOR ADMISSION

The information you provide on our application will help us to offer sensitive, professional, and comprehensive care. For this reason, we ask that it be filled out completely.

Please indicate which O.M. Fisher Home Inc. senior living community this application is intended for:

❒ Westview Meadows – Independent Living
❒ Westview Meadows – Residential Care
❒ The Gary Residence – Residential Care
❒ The Gary Residence – Memory Care

Applicant's name _____ Today's Date _____

Date of Birth _____ Age _____ Lifetime occupation _____

Address _____ City _____ State _____ Zip code _____

Telephone number _____ Applicant Email: _____

How did you hear about our senior living community? _____

_____

Please list below applicant's children and/or next of kin. Please include the contact's address and phone number in the space provided below:

Name/Relationship	Address	Phone/Email

GENERAL INFORMATION

What type of housing does applicant live in currently? ❒ House ❒ Private Apt. in Senior Housing
❒ Residential Care Home ❒ Assisted Living ❒ Nursing Home ❒ Other _____

Does applicant currently own their own home or rent? ❒ Own ❒ Rent

How long has applicant lived at this address? _____

Does applicant own an automobile? ❒ Yes ❒ No

Does applicant drive themselves regularly? ❒ Yes ❒ No

Tell us about applicant's routine: (CHECK ALL THAT APPLY)

❒ Goes out _____days per week
❒ Spends most time alone
❒ Spends most time watching TV
❒ Prefers small group activities
❒ Prefers large group activities
❒ Stays busy with hobbies (i.e., reading)
❒ Has contact with relatives/close friends _____days per week
❒ Usually attends church, synagogue, temple, etc.

What time does applicant usually get up in the morning? _____

What time does applicant usually like to go to bed? _____

How often does applicant shower/bathe? _____ days per week

Does applicant usually sleep well? ❒Yes ❒ No, applicant has trouble sleeping

Does applicant smoke? ❒Yes ❒No
If yes, how frequently: _____

Does applicant drink alcohol? ❒Yes ❒No
If yes, how much and how often does applicant drink? _____

What is applicant's typical daily routine: _____
_____
_____

Is there anything else applicant would like us to know about themselves or their daily routine? _____
_____

Please select what areas of daily life the applicant needs help with:

- **Independent** (able to do activity by oneself)
- **Minimum Assistance** (Needs to be reminded or prompted to do the activity)
- **Moderate Assistance** (Needs to be supervised while doing the activity and may require some physical help to do parts of the activity)
- **Total Assistance** (Needs full assistance from another person to do the activity

Activity	Independent	Min. Assist	Mod. Assist	Total Assist
Gathering towel & toiletries for shower				
Getting in and out of the shower				
Bathing, shampooing				
Shaving or grooming				
Choosing what to wear for the day				
Putting on clothes, socks & shoes				
Fastening buttons and zippers				
Toileting				
Cutting food/eating				
Taking medication(s)				
Using the phone				
Housekeeping				
Laundry				

Does applicant require someone (friend, relative, another person) to live with them now? ❒ Yes ❒ No

If yes, who: _____

Reason for this need? _____

If not, does applicant require someone to visit them during the day? ❒ Yes ❒ No

If yes, reason for a visit? _____

Frequency and length of visit: _____

HEALTH INFORMATION

Primary Care Physician: _____

Address (city, state, zip): _____

Phone #: _____ Fax #: _____

Neurologist: _____

Address (city, state, zip): _____

Phone #: _____ Fax #: _____

Cardiologist: _____

Address (city, state, zip): _____

Phone #: _____ Fax #: _____

Dentist: _____
Address (city, state, zip): _____
Phone #: _____ Fax #: _____

Other Specialist: _____
Address (city, state, zip): _____
Phone #: _____ Fax #: _____

Other Specialist: _____
Address (city, state, zip): _____
Phone #: _____ Fax #: _____

Is applicant receiving any of the following services? (check all that apply)

❒ Home Health Services ❒ Physical Therapy ❒ Occupational Therapy ❒ Speech Therapy
❒ Nursing Services ❒ Hospice ❒ Other: _____

How long has applicant been receiving these support services? _____

Please provide the last date applicant received the following:

❒ Tetanus Shot – Date: _____ ❒ Shingles vaccine – Date: _____
❒ Pneumovax – Date: _____ ❒ Flu Shot – Date: _____
❒ COVID vaccine – Date: _____ ❒ Other: _____ Date: _____

Please list all of the medications (prescription and over the counter) and supplements the applicant takes. If possible, please attach a copy of the most recent medication list from applicant's primary care provider.

Medication + Dose	Reason	Frequency

Does the applicant have any difficulty taking their medications? ❒Yes ❒No
If yes, please explain: _____

Please explain applicants preferred method of taking medications (For example: whole with water, crushed in applesauce, etc.) _____

Does the applicant have any allergies to medications or foods? ❒Yes ❒No

If yes, please list the allergy and explain the reaction (rash, upset stomach, throat swelling, etc.):

Medication Allergy:	Reaction:

Food Allergy:	Reaction:

GENERAL HEALTH

Height: _____ Weight: _____ Normal lifetime weight: _____

Does applicant have any skin issues or problems (i.e., sores, rashes, cuts)? ❒Yes ❒No
If yes, how are they being treated? _____

Does applicant wear dentures or a partial plate? ❒ Upper ❒Lower

Does applicant have any dental pain or concerns? ❒Yes ❒No
If yes, please explain: _____

Does applicant wear a hearing aid? ❒ Left ❒ Right ❒ Both

Does applicant wear glasses? ❒Yes ❒No

What is the applicants vision quality (with glasses if used)?
- ❒ Good
- ❒Highly Impaired – sometimes cannot identify objects
- ❒Impaired – can see large print
- ❒ Severely Impaired – no vision or sees only light

MOBILITY & TRANSFERS

Please check which best applies to the applicant:
- ❒ Independent: Able to rise from bed or chair and walk on their own (with or without assistive devices, such as a walker)
- ❒ Need Assistance: Able to rise from bed or chair with minimal assistance
- ❒ Dependent: Not able to rise from bed or chair without 1-person physical support

Does applicant need assistance or supervision with walking? ❒Yes ❒No
If yes, please describe: _____

If applicant uses an assistive device, check which one they use:

- ❒ Cane
- ❒ Walker
- ❒ Wheelchair – independent with use
- ❒ Wheelchair
- ❒ Other: _____

Has assistive device been reviewed by a Physical Therapist or Occupational Therapist? ❒Yes ❒No
If yes, by whom: _____

Are there any problems that interfere with applicant's ability to ambulate (i.e.: back pain, toe/foot pain, shuffle/gait, unsteady gait)? ❒Yes ❒No
If yes, please explain: _____

What is the approximate distance the applicant can walk before resting? _____ft. ❒N/A

Does applicant use stairs? ❒Yes ❒No

Has the applicant fallen in the last 6 months? ❒Yes ❒No
If yes, were they injured? _____

Did the fall result in a hospitalization, rehabilitation stay or require surgery? ❒Yes ❒No
If yes, please explain: _____

CONTINENCE STATUS AND MANAGEMENT

Does applicant have trouble controlling their urine? ❒Yes ❒No

Does applicant have trouble controlling their bowels? ❒Yes ❒No

Does applicant wear protective underwear or pads? ❒Yes ❒No
If yes, do they need reminding or cueing to change protective undergarments? ❒Yes ❒No

Does applicant have a history of UTI's? ❒Yes ❒No

Does applicant have a catheter? ❒Yes ❒No
If yes, how is it managed and by whom? _____

Does applicant have a colostomy? ❒Yes ❒No
If yes, how is it managed and by whom? _____

MENTAL HEALTH & COGNITIVE STATUS

Does applicant have a history of depression, anxiety, or other mental health diagnoses? ❒Yes ❒No
If yes, please describe: _____

Does applicant see a mental health provider? ❒Yes ❒No
If yes, list name and how frequently applicant sees them: _____

Has applicant ever been hospitalized for a mental health problem? ❒Yes ❒No
If yes, where and when: _____

Are there particular situations that create anxiety for the applicant? ❒Yes ❒No
If yes, what are they? _____

How is applicant's memory?

- ❒ They do not have any trouble remembering things.
- ❒ They have trouble remembering things that happened recently.
- ❒ They have trouble remembering things that happened a long time ago.
- ❒ They have trouble making decisions.

Has applicant ever left their home and not been able to find their way back? ❒Yes ❒No

Has applicant had any kind of memory or cognitive assessment? ❒Yes ❒No
If yes, please provide a copy of the most recent assessment.

Does applicant regularly see a provider to monitor cognition/memory? ❒Yes ❒No
If yes, when was applicant last seen: _____

Has applicant ever exhibited aggressive behavior? ❒Yes ❒No

Has applicant had difficulty accepting assistance/care from others? ❒Yes ❒No
If yes, please explain: _____

DIETARY

How is applicant's appetite: ❒Good ❒ Fair ❒ Poor

Does applicant feed themself? ❒Yes ❒No
If no, please explain what type of assistance they require: _____

Is applicant on a special or restricted diet? ❒Yes ❒No
If yes, please describe: _____

Does applicant have problems chewing or swallowing? ❒Yes ❒No
If yes, please describe: _____

FINANCIAL AND LEGAL INFORMATION

Party and/or family member responsible for managing applicant's affairs:

Name: _____ Relationship to applicant: _____
Address: _____
Telephone #: _____ Email: _____

Who should be contacted in the event of an emergency (emergency contact)?
Name: _____ Best method of contact: _____
Telephone #: _____ Email: _____

Does the applicant have any of the following? ***If yes, please attach a copy.***

- Living Will and/or Advance Directive? ❒Yes ❒No
- DNR/COLST Orders? ❒Yes ❒No
- An appointed healthcare agent, proxy, or Durable Power of Attorney for Health Care? ❒Yes ❒No
- Legal guardian? ❒Yes ❒No
- Financial Power of Attorney? ❒Yes ❒No
- Funeral Arrangements? ❒Yes ❒No If yes, please identify funeral home and address:
  _____

Please attach copies of all insurance cards

Social Security No.: _____ Medicare No. (or Advantage Plan): _____

Prescription insurance (Medicare RX): _____

Supplemental insurance: _____
Policy # _____ Group # _____

Does applicant have long-term care insurance? ❒Yes ❒No
(If yes, please attach copy of coverage and complete section below)

Name of Insurance Company: _____
Address: _____
Phone #: _____ Fax #: _____
Policyholder Name: _____Policy #: _____

Cash Assets (please use additional sheet if necessary, and attach)

Bank: _____

Type of account(s) (checking/savings): _____

Balance in account(s): _____

Real Estate Assets (please use additional sheet if necessary, and attach)

Does applicant own their home? ❒Yes ❒No

Does applicant live in the home? ❒Yes ❒No

Value of home/property: $_____ (please attach property tax assessment)

Is the home in a life estate or ladybird deed? ❒Yes ❒No

Does applicant own any other property? ❒Yes ❒No

Sources of income:

Social Security	$ _____
Supplemental Security	$ _____
VA Pension	$ _____
Retirement Pension	$_____
Trust Fund	$_____
Annuities	$ _____
Other	$ _____

Other Assets

Please list other assets and their value such as stocks, bonds, life insurance with a cash value, etc.:

_____

_____

Please attach a copy of 2 previous years' tax returns, statements, e.g., current bank or brokerage statements that substantiate any liquid assets listed on this financial statement.

AUTHORIZATION

I attest, under penalty of perjury, that everything stated in this application is true and correct. I agree to provide copies of all Bank Statements and Investment Account Statements that are stated above to this financial statement. I also agree to provide my 2 previous year's tax returns and proof of income. I agree to furnish additional financial information as may be required from time to time during my residency and to report any major changes in financial status as soon as possible. During my residency, I will not transfer or reduce those resources that are needed to carry out my commitments to O.M. Fisher Home Inc. I certify that that information contained in this financial statement is true. O.M. Fisher Home Inc. will keep all of this information strictly confidential. I agree that a photocopy shall have the full force and effect as the original of this application.

_____ _____

Applicant's Signature Date

_____ _____

Signature of DPOA / Responsible Party Date