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

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 is be filled out completely.

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

❒ Westview Meadows – Independent Living
❒ The Gary Residence – Residential Care
❒ Westview Meadows – 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 ________________________ 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 #: ____

Dentist: ____

Address (city, state, zip): ____

Phone #: ____ Fax #: _____________________________________

Optometrist: ____

Address (city, state, zip): ____

Phone #: ____ Fax #: _____________________________________

Neurologist: ____
Address (city, state, zip): ____
Phone #: ______________________________ Fax #: ______________________________

Cardiologist: ____
Address (city, state, zip): ____
Phone #: ______________________________ Fax #: ______________________________

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

Are there any problems or concerns that our staff should be aware of or any special support applicant might need in our community?

❒ Home Health Services ❒ Physical Therapy ❒ Occupational Therapy ❒ Speech Therapy
❒ Nursing Services ❒ 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:

Health/Medical Problems or Diagnoses:		

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 applicants' 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?

- ❐ I don't have any trouble remembering things.
- ❐ I have trouble remembering things that happened recently.
- ❐ I have trouble remembering things that happened a long time ago.
- ❐ I have trouble making decisions.

Have 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

Is applicants' 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): _________________________ Part A: ___________ Part B:___________

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: ____
Address: ____
Type of account(s) (checking/savings): ____
Balance in account(s): ____

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

Does applicant own home? ❒Yes ❒No
Does applicant live in the home? ❒Yes ❒No
Value of home/property: $_______________ (please attach property tax assessment if possible)
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	$___________________________
Rental	$ ___________________________
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 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