APPLICATION FOR:

Skilled Nursing

CEDAR HILL HEALTH CARE CENTER

Dementia Care

JUDITH B. BROGREN MEMORY CARE CENTER

Independent & Assisted Living

THE VILLAGE

Date:____/____/_____ _____ _____ _____

Resident's Name:_____

Birth Date: _____ Age: ____ Birthplace: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address if different: _____

Length of time at this address: _____years _____months Phone Number: _____

What state is the applicant a resident of? _____

Spouse's Name: _____ Years married: _____

Marital Status: S M W D

If married, is spouse Living? ____

Name: _____

Spouse's Address: _____

Spouse's Phone Number: _____

Social Security Number: _____/____/_____ Medicaid #: _____

Medicare #: _____ Part A: _____ Part B: _____

Name of Health Insurance: _____

Policy #: _____

Veteran's Administration #: _____

Where does the veteran go for medical care? _____

Does resident have any other insurance that will cover the cost of living at Cedar Hill, such as long term care insurance? Yes No

Name of Policy: _____

Policy #: _____

Address: _____

Telephone Number: _____

How did you hear about Cedar Hill? _____

If resident has children or next of kin, please list with addresses and phone numbers on a separate piece of paper and attach to application.

Legally Responsible Party Information

Durable Power of Attorney – Financial

Name: _____

Address: _____

_____

_____

Tel (H): _____

Tel (W): _____

Tel (C): _____

Email: _____

Durable Power of Attorney – Health

Name: _____

Address: _____

_____

_____

Tel (H): _____

Tel (W): _____

Tel (C): _____

Email: _____

Legal Guardian

Name: _____

Address: _____

_____

_____

Tel (H): _____

Tel (W): _____

Tel (C): _____

Email: _____

Other Emergency Contacts:

_____

_____

_____

_____

_____

_____

_____

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

Name: _____

Relationship to Resident: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephones (H): _____ (W): _____ (C): _____

Best Email Address:

_____

Occupation: _____

Will the legally responsible party help defray the cost of long term care: Yes No

To what extent: _____

_____

_____

_____

Medical Information

Applicant is currently living:

_____ At home with family
_____ At home with caregivers
_____ At home alone
_____ In Hospital Name of Hospital: _____

Admit Date: _____ Physician: _____

Reason: _____

_____ Other Facility Name: _____

If at home, have there been any hospitalizations within the past 60 days? No Yes Circle One

If yes, please enter the name of the hospital: _____

Admit Date: _____ Discharge Date_____

Reason: _____

Hospital Physician: _____

Resident's last hospitalization if not in the past 60 days or currently: _____

Reason for that hospitalization: _____

How long was resident hospitalized? _____

Has the resident ever been in a nursing home or Assisted Living/Residential Home?_____

If yes, give dates and name of home: _____

Reason for admission: _____

Reason for discharge: _____

Name of Resident's Primary Physician: _____

Name of Practice: _____

Address: _____

Telephone Number: _____

Current Medical Problems: _____

_____

_____

_____

Past Medical Problems: _____

_____

_____

_____

_____

Please list all sensitivities and allergies, especially to food and medications:

_____

_____

_____

Please list all the medications the applicant is currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Does applicant have a Living Will? Yes No

Is the applicant a body/organ donor? Yes No

Does the applicant have planned burial/funeral arrangements? Yes No

If yes, name of facility: _____

Contact person: _____ Telephone Number: _____

Health and Financial Status of Applicant

Mobility

Resident walks: independently _____ with a walker _____ with a cane _____

Resident needs assistance when walking _____

Resident is not able to walk _____Resident uses a wheelchair _____

Resident is independent in wheelchair _____ Needs assistance in wheelchair _____

Resident is able to transfer from bed to chair _____ Needs assistance _____

Doe the resident need assistance from one person or two: _____

Resident is bed bound _____

Dietary

Resident cooks for self _____

Resident feeds self _____ Needs assistance with feeding _____

Resident is on a regular diet _____ A special diet (Please specify) _____

_____

Is the applicant a diabetic: YES NO

If yes, the treatment prescribed is: DIET MEDICATION INSULIN INJECTIONS

If resident uses insulin who injects it: SELF OTHER PERSON

Appetite is (circle one): GOOD FAIR POOR

Food likes and dislikes (please list):

_____

_____

Present weight: _____ Normal lifetime weight: _____

Has there been a recent weight gain or loss: YES NO If so, how many pounds: _____

Present Height: _____

Describe use of alcohol and tobacco: _____

_____

Resident's Care Needs

Please circle the most accurate response possible regarding the applicant's need for help in the following areas:

Dressing	Independent	Some Assistance	Full Assistance
Bathing	Independent	Some Assistance	Full Assistance
Showering	Independent	Some Assistance	Full Assistance Time of Day Preference AM or PM
Tub Bath	Independent	Some Assistance	Full Assistance Time of Day Preference AM or PM
Grooming	Independent	Some Assistance	Full Assistance
Eating	Independent	Some Assistance	Full Assistance
Standing	Independent	Some Assistance	Full Assistance
Sitting	Independent	Some Assistance	Full Assistance
Toileting	Independent	Some Assistance	Full Assistance
Taking Medications	Independent	Some Assistance	Full assistance

If the resident needs assistance is he or she cooperative with assistance? _____

_____

_____

If the resident needs help with medications, please tell us the help he or she needs: _____

_____

Is the resident continent of bowel? _____ of bladder? _____

Does the resident have incontinent episodes on occasion? _____

How often? _____

Does the resident have incontinent episodes only at night? _____

How often? _____

Does the resident wear disposable briefs? _____

Need assistance with changing and cleaning self? _____

History of constipation: _____

History of urinary tract infections: _____

Does the resident need skin care? _____

Does the resident have any pressure sores? _____

Describe the sore and what care is required?

_____

Have there been any recent changes in the resident's care needs? _____

_____

_____

Is resident presently receiving any assistance from outside agencies such as Home Health or in-home aides?
_____

What agency is providing the service? _____

How often does this agency provide service to the resident? _____

What types of services are provided by the agency staff? _____

_____

How is the applicant's vision? Good Fair Poor Blind

Does the resident wear glasses? _____

Last eye exam: _____

Name and contact information for eye doctor: _____

_____

How is the applicant's hearing? Good Fair Poor Deaf

Does the resident wear a hearing aid? _____

Does the resident wear dentures? _____ Upper _____ Lower _____

Last dental exam: _____

Name and contact information for dentist:

_____

_____

Does the resident use oxygen? _____ how often? _____

What is the resident's sleep pattern? Sound sleeper _____

Up at night _____ How often _____ Naps for more than one hour during day_____

Mental Status

(Please check all that apply.)

Is the resident oriented to: Person _____ Time _____ Place _____

Forgetful _____ Difficulty expressing self _____

Episodes of delusional thinking _____ Paranoid: _____

Wanders _____ at risk for wandering out of building _____

May wander into other resident's rooms _____

Generally quiet _____ talkative _____ Noisy _____

Easily agitated _____ can be combative _____ Verbally abusive _____

Sociable _____ Withdrawn _____ Reclusive _____

Depressed moods _____ has been treated for depression in the past _____

Does the resident have crying episodes? _____

Is presently being treated for depression? _____

History of problems with anxiety? _____

Is presently being treated for anxiety? _____

Have there been any recent changes in mental status? _____

Does resident accept need for placement? _____

Please provide any other information that may be helpful in assessing the applicant:

Personal History

Resident's level of education: to Grade 8 9 10 11 12 College Other

Work/Career history:_____

_____

_____

Did the resident serve in the Armed Forces?_____ What branch? _____

Did he or she serve during a war? _____

Was he or she involved in combat? _____

Primary language spoken? _____

Other languages spoken? _____

Does the resident have any hobbies? (i.e.) enjoys TV, reading, knitting, painting, music, chess, bingo, cards, etc.

_____

_____

What other activities does the resident enjoy (exercise, trips to restaurants, musical entertainment, crosswords)?

_____

_____

Please list any other interests or activities the resident enjoys?

_____

Cedar Hill offers many spiritual activities. Is religion important in the resident's life? Yes No

If yes, what denomination? _____

Would the resident appreciate attending our in-house religious activities? _____

Does the resident generally have a regular hairdresser appointment? _____

How often? _____

Do you anticipate the resident will be able to return home at some point in the future? _____

Please use the remaining space to tell us anything about the resident that would be helpful in developing his or her own individualized plan of care:

You **must** provide the following documents (as assigned by the applicant or court) with the application or before date of admission:

Copy of Financial Power of Attorney
Copy of Health Care Power of Attorney
Copy of Guardianship
Copy of COVID Vaccination Card
Copy of Body/Organ Designation
Copy of Living Will/Advance Directive
Copy of Vermont Advance Directory Registration (if registered)
Copy of Social Security Card
Copy (front and back) of Medicare Card
Copy (front and back) of other insurance cards
Copy (front and back) of Medicare Part D prescription drug card
Copy (front and back) of Veteran's Administration card.
Documentation of financial assets

In order to obtain the necessary Medical information required for assessment, please **SIGN** and **RETURN** with the application the enclosed **MEDICAL RELEASE**. We cannot admit any residents without full medical information provided in advance.

Prior to the day of admission, please be prepared to pay for a month in advance.

Notice

- The Vermont Advance Directive Registry is a secure, web-based database created by the Commissioner of Health to which individuals may submit an advance directive or information regarding the location of an advance directive.
- To learn more access: http://healthvermont.gov/vadr/ or call the Vermont Department of Health(1-800-863-7300).
- Cedar Hill is required to access this registry, enroll residents (if they choose to do so), and maintain accurate and up to date advance directive information for residents who are registered prior to admission or wish to do so after admission to Cedar Hill Continuing Care Community.

Required Financial Information

Will the resident pay for his or her stay out of her own funds: YES NO

Has the resident applied for and will the resident be applying for government assistance such as Medicaid?

If the resident has applied, what was the date? _____

Where? _____

Does resident have a funeral trust? _____

Funeral Service Provider: _____

Phone: _____

Cash assets

(Please use additional sheets if necessary.)

1. Checking Account Number: _____

Balance $_____ as of Date: _____

Bank Name/Address/Telephone and Contact Person:

_____

_____

2. Checking Account Number: _____

Balance $_____ as of Date: _____

Bank Name/Address/Telephone/Contact Person:

_____

_____

3. Checking Account Number: _____

Balance $ _____ as of Date: _____

Bank Name/Address/Telephone/Contact Person:

_____

_____

_____

1. Savings Account Number: _____

Balance $_____ as of Date: _____

Bank Name/Address/Telephone/Contact Person:

_____

_____

2. Savings Account Number: _____

Balance $: _____ as of Date: _____

Bank Name/Address/Telephone/Contact Person:

Real Estate Assets

(Please use additional sheet if necessary.)

Does resident own a home? Yes No

Personal Residence Fair Market Value $_____

Address: _____

_____

Does anyone live in the home other than resident? Yes No

Relationship: _____

Does anyone own the home with the resident? Yes No

If yes, who and relationship: _____

Does resident own any other real estate? Yes No

If yes, address or addresses of the property:

_____

_____

Fair Market Value $: _____

Does resident receive any "rental" income? Yes No

How much per month? _____ Per Year? _____

Stock and Mutual Fund Assets

(Please use additional sheets if necessary.)

Does the resident own any individual stocks? Yes No

Stock Names, Number of Shares and value:

_____

_____

_____

_____

Does the resident have any mutual funds held outside of an IRA? Yes No

1. Mutual Funds, Number of Shares and value:

_____

_____

_____

Other Stock or Mutual Assets, such as IRAs, Name and Value:

Other Assets

(Please use additional sheets if necessary.)

Please list other assets, and their value, such as life insurance with a cash value, trust funds, certificates of deposit, collections, etc.

Income per Month

Social Security: $_____

Supplemental Security: $ _____

Pension monthly amount: $_____

VA Pension: $ _____

Retirement Pension: $_____

Trust Fund: $ _____

Annuity monthly/quarterly amount: $_____

Dividend Income: $ _____

Interest Income: $ _____

Disability monthly amount: $_____

Other: $ _____

Total: $ _____

Financial Information Concerning Sponsor

Will responsible party pay for the resident's stay? Yes No

Will responsible party use resident's assets toward resident's stay? Yes No

If the responsible party will pay for the resident, then responsible party must answer questions as found in the financial information section of this application.

Thank you for filling out this application. Please remember to send us documentation of resident's assets.

I, _____, attest under penalty of perjury, that everything in this application is true and correct. I understand that Cedar Hill Continuing Care Community will check my financial references and credit history. I agree to notify Cedar Hill Continuing Care Community in writing if any significant change occurs in the applicant's financial condition. Cedar Hill Continuing Care Community agrees to keep this information strictly confidential. By signing below, I swear that I have the legal authority to authorize the financial information concerning:

_____

to be released to Cedar Hill Continuing Care Community and so authorize that release. I agree that a photocopy shall have the full force and effect as the original of this application.

SIGNATURE:_____ **DATE:** _____

PRINTED NAME: _____

SIGNATURE IS APPLICANT'S_____ **RESPONSIBLE PARTY**_____