Ida's House of Vermont
Level III Residential Care Home

Resident Pre-Admission Application

Please Check One:

☐ Medicaid/ACCS/ERC
☐ Private Pay

Ida's House of Vermont
Level III Residential Care Home
360 New Road
Brandon, VT 05733
(802) 779-7385

Applicant Name: _____
Current Address: _____
_____

Phone: _____ DOB:_____

Gender: (Circle) MALE FEMALE

Social Security Number: _____

Marital Status: (Circle) Married Single Widowed Divorced

Health Insurance Information

Medicare #: _____ Medicare Part A? ☐ Yes ☐ No
Medicare Part B ? ☐ Yes ☐ No
Medicaid? ☐ Yes ☐ No If yes, Medicaid #: _____
Do you have other health, accident or income protection insurance? ☐ Yes ☐ No
If yes, Name of Company: _____
Address:_____
Policy #_____
Brief Description: _____

Applicants primary diagnosis?_____

Allergies: _____

Religious Affiliation: _____

Responsible Party / Emergency Contact:
_____
_____
Phone: _____ Email: _____

Preferred Date of Admission: _____

Why would you like to be considered for admission to this home?
_____
_____

Primary Care Physician : _____

Phone: _____

- Will this physician be retained during your residence at this home?
  ☐ Yes ☐ No ☐ Use in house provider

***We will need a current medication list and any standing orders. Both forms must be signed by the physician 48 hours prior to the admission date.** *

General Information

1. Do you have a power of attorney? ☐ Yes ☐ No
If yes, please provide:
Name: _____
Address: _____
Phone: _____

2. Do you have an Advanced Directive for Healthcare / or Living Will?
Advanced Directive: ☐Yes ☐No Living WIll: ☐Yes ☐ No

****We will need copies of these documents before admission****

3. Do you have pre-planned funeral arrangements? ☐ Yes ☐ No
If yes, Name of Funeral Home: _____
Address:_____
Phone:_____

Functional and Health Information

1. During the last 6 months, how many times have you seen your physician?
_____

2. How many times in the past 6 months were you in the hospital for health issues? _____

3. What were the dates of your stay, if any? _____
4. What were you hospitalized for?

_____

_____

5. Have you fallen in the last 6 months? ☐Yes ☐ No

6. Do you use oxygen? ☐ Yes ☐ No Nebulizier? ☐Yes ☐No

7. Do you have periods of confusion or forgetfulness that interfere with your daily activities? ☐ Yes ☐ No

8. Do you need assistance with taking your medications? ☐ Yes ☐No
If yes, please describe: _____

9. Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list what medications you are allergic to and the reaction you had.

_____

_____

10. Any food allergies? ☐ Yes ☐ No?
If yes, What food, and reaction did you have?

_____

_____

11. Do you need an assistive device to get around? ☐ Yes ☐ No

If Yes (please check) ☐ Cane ☐ Walker ☐ Wheelchair ☐ Person's arm

12. Do you use any of the following:
(Please check) ☐ Hearing aids ☐ Dentures

13. How is your eyesight? _____

14. Do you have an eye doctor? ☐ Yes ☐ No
If yes, Name: _____ Phone: _____

15. If yes, when was your last eye exam? _____

16. Do you consume alcoholic beverages? ☐Yes ☐ No

****If yes, your primary care physician must include in signed orders how much alcohol can be consumed daily.****

17. Have you ever had any problems with alcohol? ☐ Yes ☐ No

18. Do you use any tobacco products? ☐ Yes ☐ No

19. Do you use cannabis? ☐ Yes ☐ No

20. Do you have any physical problems or illness at the present time that seriously affect your health? ☐ Yes ☐ No

21. Do you feel that you need medical care or treatment beyond what you are receiving at this time? ☐ Yes ☐ No

22. How would you rate your mental or emotional health at this time?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

23. Do you wear incontinence briefs? ☐ Yes ☐ No
If yes, ☐ 24 hours ☐ Bedtime
Do you have a prescription for them? ☐ Yes ☐ No

24. Do you have any dietary restrictions? ☐ Yes ☐ No
If yes, Please explain?

_____

_____

25. Are you diabetic? ☐ Yes ☐ No
If yes, Insulin Dependent? ☐ Yes ☐No Pills? ☐ Yes ☐ No

Nutritional Information

Applicant's current weight: _____
Applicant's current height: _____

Weight loss in the last 6 months? ☐ Yes ☐No If yes, How much? _____
Problems swallowing? ☐ Yes ☐ No
Has the applicant been told he/she is dehydrated? ☐ Yes ☐ No
Does he/she drink fluids provided? ☐ All ☐ Most

Daily Living Activities

Bed Mobility: ☐ Self ☐ Cues ☐ 1 assist ☐ 2 assist ☐ total care
Transferring: ☐ Self ☐ Cues ☐ 1 assist ☐ 2 assist ☐ total care
Walking: ☐ Self ☐ Cues ☐ 1 assist ☐ 2 assist ☐ total care
Eating: ☐ Self ☐ Cues ☐ 1 assist ☐ total care
Toileting: ☐ Self ☐ Cues ☐ 1 assist ☐ 2 assist ☐ total care

Thought Process

Short-term memory problems? ☐Yes ☐No
Applicant know where they are? ☐Yes ☐No
Applicant know the season? ☐ Yes ☐No
Applicant know significant people? ☐Yes ☐No
Decision making ☐Self ☐With Cues ☐Cues and Assistance ☐None
Does the applicant see or hear things that are not there? ☐ Yes ☐No
Does the applicant believe things that are not possible? ☐Yes ☐ No

Behavioral Issues

Any behavioral issues? ☐Never ☐Weekly ☐ Daily
If yes, explain:

_____

_____

Wanders? ☐Yes ☐No
Verbal Abuse? ☐Yes ☐No
Physical? ☐Yes ☐No
Inappropriate in ways? ☐Yes ☐No
Explain:_____

Skin Issues

- Burns: ☐Yes ☐No If yes, Where? _____
- Skin Tears/Cuts: ☐Yes ☐No If yes, Where? _____
- Bed Sores: ☐Yes ☐No If yes, Where? _____
- Surgical Wounds: ☐Yes ☐No If yes, Where? _____
- Stasis Ulcers: ☐Yes ☐No If yes, Where? _____
- Open Wound Areas: ☐Yes ☐No If yes, Where? _____
- Bruises: ☐Yes ☐No If yes, Where? _____
- Neglected Areas: ☐Yes ☐No If yes, Where? _____

Financial Information

Income: List all income from all sources; including but not limited to:

- Wage/ Salary
- Welfare

- Social Security
- Veteran's Pension
- Worker's Compensation
- Interest
- Alimony
- Annuities
- Dividends
- Proceeds from Rental Property, Etc

(Attach an additional sheet if necessary)

Source Amount Received: _____
How often received:_____
Name and Address to verify: _____

Assets

Please list all Bank Accounts, including: Savings, Checking, Bonds, Cd's, Cash Value of Life Insurance, and other assets.

_____
_____
_____
_____

Real Estate

Please list all real estate in which you have ownership interest, if any
Type:
Address:
Fair Market Value:
Mortgage Holder:
Balance

Do you anticipate any changes in income and assets (including real estate ownership) within the next 12 months? ☐ Yes ☐No
If yes, explain:

_____
_____
_____

For Private Pay

How long will you pay private pay?_____

Dates:_____

State any other information which you think would be helpful in processing this application:

_____

_____

_____

_____

Residence in which services may be required by our funding sources to document the eligibility of the residents, and for this reason financially without further notice to the applicant. By law, the Vermont department of Aging and Disabilities is entitled to resident's certification.

Statement of applicant or legally authorized representative.

I hereby certify that all information provided on this application is true and complete to the best of my knowledge.

_____ _____

Signature of Applicant *Signature of Legal Representative*

_____ _____

Date *Date*

***If a legally authorized representative has signed on behalf- of the applicant, please attach documentary evidence indicating the extent and legal nature of this legal authorization.*

Physician Signature: _____

Date: _____