THE MANOR

577 Washington Hwy
Morrisville, VT 05661
802-888-8700

Resident Application

Prospective Resident Name _____

Date of Birth _____

Social Security Number _____

Address _____

Phone _____

I. General Information

1. **Primary Physician** _____

   Phone _____

2. **Will this physician be retained during residence at The Manor?**

   ☐ Yes ☐ No

3. **Do you handle your own business affairs?**

   ☐ Yes ☐ No

4. **If no, who handles these affairs?**

   Name _____ Phone _____

   Address _____

   Relationship to you _____

5. **Do you have a Living Will?**

☐ Yes ☐ No

6. **Do you have Advance Directives?**

☐ Yes ☐ No

7. **Do you have prearranged burial services?**

☐ Yes ☐ No

8. **Funeral home** _____

9. **Have you had your COVID vaccination?**

☐ Yes ☐ No

If yes, which vaccination and what were the dates of vaccination?

_____

_____

_____

10. **Do you have a Medical Power of Attorney?**

☐ Yes ☐ No

If yes, please provide:

Name _____

Address _____

Relationship _____ Phone _____

11. **Have you assigned a Power of Attorney for legal and financial decisions?**

☐ Yes ☐ No

If yes, please provide:

Name _____

Address _____

Relationship _____ Phone _____

12. Do you have a Guardian?

☐ Yes ☐ No

If yes, please provide:

Name _____

Address _____

Relationship _____ Phone _____

13. Why would you like to be considered for admission at The Manor?

14. What did you do for work most of your life?

15. What are your interest/hobbies?

II. Functional Assessment

1. **During the past six months, how many times have you seen a doctor?** _____

2. **During the past six months, how many days were you sick that you were unable to carry on your usual activities?**

   ☐ None ☐ A week or less ☐ More than a week

3. **How many days in the past six months were you in a hospital?** _____

4. **Why were you hospitalized?**

5. **How would you rate your overall health at the present time?**

   ☐ Excellent ☐ Good Fair ☐ Poor

6. **How would you rate your overall health compared to a year ago?**

   ☐ Better ☐ About the same ☐ Worse

7. **How much do your health problems stand in the way of your doing the things you want to do?**

   ☐ Not at all ☐ A little ☐ A great deal

8. **Do you sometimes have confusion or forgetfulness that interferes with your daily activities?**

   ☐ Yes ☐ No

   If yes, explain:

9. Do you have any of the following illnesses at the present time?
If "Yes", check the box which corresponds how much it interferes with activities.)

	None	A Little	Greatly
Arthritis or Rheumatism	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Breathing problems such as Asthma, Emphysema, or Chronic Bronchitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid or Other Glandular Disorders	☐	☐	☐
High Blood Pressure	☐	☐	☐
Heart Trouble	☐	☐	☐
Circulation Trouble in Arms or Legs or Head	☐	☐	☐
Diabetes	☐	☐	☐
Ulcers (of digestive system)	☐	☐	☐
Other Stomach or Intestinal Disorders	☐	☐	☐
Cancer or Leukemia	☐	☐	☐
Effects of Stroke	☐	☐	☐
Parkinson's Disease	☐	☐	☐
Epilepsy	☐	☐	☐
Cerebral Palsy	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Muscular Dystrophy	☐	☐	☐
Effects of Polio	☐	☐	☐
Pressure Sores, Leg Ulcers or Burns	☐	☐	☐
Speech Impediments or Impairment	☐	☐	☐
Dementia, Senility, or Cognitive Disorders	☐	☐	☐
Swallowing Problems	☐	☐	☐
Bleeding Problems	☐	☐	☐
Walking Problems	☐	☐	☐
Balance Problems	☐	☐	☐
Hearing Problems	☐	☐	☐
Vision Problems	☐	☐	☐
Other Conditions Not Mentioned Above (describe)	☐	☐	☐

10. This is a list of common medicines that people take.
Please check "Yes" after any medication you are taking now or have taken during the past month.

	Yes	No
Arthritis medication	☐	☐
Prescription painkillers (other than above)	☐	☐
High blood pressure medicine	☐	☐
Pills to make you lose water (water pill)	☐	☐
Heart pill	☐	☐
Blood thinner medicine (anticoagulants)	☐	☐
Insulin injections for diabetes	☐	☐
Pills for diabetes (sugar pills)	☐	☐
Seizure medications (like Dilantin)	☐	☐
Thyroid pills	☐	☐
Cortisone pills or injections	☐	☐
Antibiotics	☐	☐
Medicine for nerves or depression	☐	☐
Prescription sleeping pills (once a week or more)	☐	☐

11. What other medications have you taken in the past month?

12. Do you need assistance taking your medicines?

☐ Yes ☐ No

If yes, describe:

13. Are you allergic to any medications or food?

☐ Yes ☐ No

Please list:

Please specify which reaction you experience:

14. Do you have dietary restrictions (no salt, sugar, etc.?)

☐ Yes ☐ No

If yes, explain:

15. Do you have difficulty eating?

☐ Yes ☐ No

If yes, explain

16. Do you use any of the following aids?

☐ Wheelchair ☐ Cane ☐ Walker ☐ Glasses

☐ Dentures ☐ Hearing Aid ☐ Other:

17. How is your eyesight?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Totally Blind ☐ Wear Glasses ☐ Wear Contacts Lenses

18. Do you use tobacco products?

☐ Smoke ☐ Chew

If you smoke: ☐ Cigarettes ☐ Cigars ☐ Pipe

19. Do you have any physical problems or illness at the present time that seriously affect your health?

☐ Yes ☐ No

If yes, explain:

20. Do you feel that you need medical care or treatment beyond what you are receiving at this time?

☐ Yes ☐ No

If yes, explain:

21. Do you walk?

☐ Alone ☐ Alone with cane, walker, etc.

☐ Can walk only with help of a person ☐ Cannot walk

22. Do you have difficulty in keeping your balance while walking?

☐ Yes ☐ No

23. Is your sleep disturbed?

☐ Yes ☐ No

24. How many hours each night do you usually sleep? _____

25. Are you troubled by your heart pounding or by shortness of breath?

☐ Yes ☐ No

26. Taking everything into consideration, how would you describe your satisfaction with life in general at the present time?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

27. How would you rate your mental or emotional health at the present time?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

28. Compared to one year ago, how would you rate your mental or emotional health?

☐ Better ☐ About the same ☐ Worse

29. Do you use the telephone?

☐ Without help ☐ With some help

☐ With adaptive technology ☐ Unable to use telephone

30. Do you cook meals for yourself?

☐ Without help ☐ With some help ☐ Unable to cook meals

31. Without wanting to, have you lost or gained 10 pounds or more in the last six months?

☐ Yes ☐ No

32. Do you handle your own money?

☐ A. Without help (write checks, pay bills, etc.)

☐ B. With some help (manage day-to-day buying, but need some help with managing the checkbook and paying your bills)

☐ C. I don't handle my own money

33. Do you eat?

☐ A. Without help (able to feel yourself completely)

☐ B. With some help (need help cutting meat etc.)

☐ C. With total help

34. Do you dress and undress yourself?

☐ Without help ☐ With some help ☐ With total help

35. Do you care of your own appearance; for example, combing your hair, and (for men) shaving?

☐ Without help ☐ With some help ☐ With total help

36. Do you get in and out of bed

- [ ] Without any help or aids
- [ ] With some help (either from a person or with aid of some device).

If device, explain:

- [ ] With total help

37. Do you take a [ ] **Bath** (or) [ ] **Shower**

- [ ] Without help
- [ ] With some help (need help getting in and out of tub, or need special attachments on the tub.

Please explain:

- [ ] With total help

38. Do you ever have trouble getting to the bathroom on time?

- [ ] No, never
- [ ] Yes, sometimes
- [ ] Have catheter or colostomy

39. During the past six months, have you had any help with such things as shopping, cooking, taking medications, housework, bathing, dressing, and getting around?

- [ ] Yes
- [ ] No

40. If you answered "Yes" to question 39 above, who is your major helper?

Name _____

Relationship _____

Health Insurance

A. Medicare Number _____

B. Do you have Medicare Part A? ☐ Yes ☐ No

C. Do you have Medicare Part B? ☐ Yes ☐ No

D. Medicaid Number (if any) _____

E. Do you have a Medicare Supplemental Policy? ☐ Yes ☐ No

If Yes, Name _____

If Yes, Policy # _____

F. Do you have a Medicare Part D plan? ☐ Yes ☐ No

If Yes, Name _____

If Yes, Policy # _____

G. Other health, accident or income protection insurance? ☐ Yes ☐ No

If Yes, name of company _____

Address _____

Policy # _____

Brief Description:

PLEASE ATTACH COPIES OF ALL INSURANCE CARDS, BOTH SIDES

Financial Statement

Do you have a bank trust department or other agent who manages your financial affairs?

☐ Yes ☐ No

If yes, please provide name _____

Address _____

Relationship _____

A. INCOME: List all income from all sources; including but not limited to wages/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	Name and Address to Verify

How many people in total live on your income? _____

B. ASSETS: List all bank accounts, including savings and checking, stocks and bonds, CDs, cash value of life insurance, and all other assets with the exception of real estate (use back of sheet if necessary):

Asset	Value	Acct #	Name and Address to Verify

C. REAL ESTATE: List all real estate in which you have ownership interest.

Type and Address of Property	Fair Market Value	Mortage Holder	Mortage Balance

D. EXPENSES: List all expenses you pay on a regular basis (rent, car payments, household expenses, etc.)

Name and Address to Whom Paid	Amount Paid	Balance Owed	Account Number

E. Do you anticipate any changes in income or assets (including real estate ownership) within the next twelve months?

☐ Yes ☐ No

If yes, explain:

F. Do you have any sources of financial support not listed above?

☐ Yes ☐ No

If yes, explain:

G. State any other information which you would expect to be helpful in processing this application.

H. How did you hear about us?

Release Form

Dear Sir and Madam:

The person identified below has applied for residence, or is being re-evaluated for continued residency, at The Manor. In order to determine his/her suitability and eligibility for residence, and to determine services required, we need the information requested on the attached form. With respect to financial information, we are required to verify income and assets of our residents.

To comply with these requirements, we ask your cooperation in supplying the information requested on the attached form for the person identified below. This information will be held in strict confidence for use only for the purpose described above.

Thank you for your consideration.

Sincerely, _____

Date _____ Social Security # _____

Inquiry in Reference to: Name _____

Mailing Address _____

Legal Address _____

I hereby authorize The Manor and its agents to contact any individuals, agencies, offices, groups or organizations to obtain any information or materials deemed necessary to verify my suitability of eligibility for residence and services which I may require at The Manor. I further authorize any of those contacted to release the information requested to The Manor and its agents.

Signature _____

The information on this Application form is to be used by The Manor and its agents to assist in determining the eligibility and suitability of the applicant for residency at The Manor and which services may be required. We are required by our funding sources to document the eligibility of residents, and, for this reason financial information on this form may be disclosed to these funding sources without additional notice to the applicant. By law, the Vermont Department of Health is entitled to resident's medical and health records for the purpose of licensing and certification.

Statement of Applicant or Legally Authorized Representative:

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

_____	_____
Signature of Applicant	Signature of Legal Representative
_____	_____
Printed Name of Applicant	Printed Name 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 nature of this legal authorization.