

The Manor, Inc. Resident Application

Prospective Resident Name: _____

Date of Birth: _____

Social Security Number: _____

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 a Medical Power of Attorney? Yes No

If yes, please provide

Name: _____

Address: _____

Relationship: _____ Phone #: _____

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8. Have you assigned a Power of Attorney for legal and financial decisions? Yes No

If yes, please provide

Name: _____

Address: _____

Relationship: _____ Phone #: _____

9. Do you have a Guardian? Yes No

If yes, please provide

Name: _____

Address: _____

Relationship: _____ Phone #: _____

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

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

12. What are your interest/hobbies? _____

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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? (Circle One)

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?

(Circle One) Excellent Good Fair Poor

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

(Circle One) 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? (Circle One) 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: _____

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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)			

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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 _____

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16. Do you use any of the following aids? (Circle, if applicable) Wheelchair Cane
Walker Glasses Dentures Hearing Aid Other: _____
17. How is your eyesight? (Circle) Excellent Good Fair Poor
Totally Blind Wear Glasses Wear Contacts Lenses
18. Do you use tobacco products? (Circle) Smoke Chew
If you smoke (Circle) 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? (Circle one) 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?
(Circle one) Excellent Good Fair Poor
27. How would you rate your mental or emotional health at the present time?
(Circle one) Excellent Good Fair Poor

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

(Circle one) Better About the same Worse

29. Do you use the telephone? (Circle one)

Without help With some help

With Adaptive Technology Unable to use telephone

30. Do you cook meals for yourself? (Circle one)

Without help With some help Unable to cook meals

31. Without wanting to, have you lost or gained 10lbs 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?

A. Without help

B. With some help

C. With total help

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35. Do you care of your own appearance; for example, combing your hair, and (for men) shaving?
- A. Without help
 - B. With some help
 - C. With total help
36. Do you get in and out of bed
- A. Without any help or aids
 - B. With some help (either from a person or with aid of some device).
If device, explain: _____
 - C. With total help
37. Do you take a (please circle) Bath (or) Shower
- A. Without help
 - B. With some help (need help getting in and out of tub, or need special attachments on the tub. Please explain: _____)
 - C. With total help
38. Do you ever have trouble getting to the bathroom on time?
- A. No, never
 - B. Yes, sometimes
 - C. 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?
- A. Yes
 - B. No

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

Name: _____

Relationship: _____

Health Insurance

1. Medicare Number: _____

2. Do you have Medicare Part A (Circle one) Yes No

3. Do you have Medicare Part B (Circle one) Yes No

4. Medicaid Number (if any): _____

5. Do you have Blue Cross/Blue Shield, 65 Extended Policy? (Circle One) Yes No

If Yes, Policy # _____

6. 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

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Financial Statement

Do you have a bank trust department or other agent who manages your financial affairs?
(Circle one) 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).

<u>SOURCE</u>	<u>AMOUNT RECEIVED</u>	<u>HOW OFTEN</u>	<u>NAME & ADDRESS TO VERIFY</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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):

<u>ASSET</u>	<u>VALUE</u>	<u>ACCT #</u>	<u>NAME & ADDRESS TO VERIFY</u>
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_____	_____	_____	_____
_____	_____	_____	_____

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

<u>TYPE & ADDRESS OF PROPERTY</u>	<u>FAIR MARKET VALUE</u>	<u>MORTGAGE HOLDER</u>	<u>MORTGAGE BALANCE</u>
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D. EXPENSES: List all expenses you pay on a regular basis (rent, car payments, Household expenses, etc.)

<u>NAME & ADDRESS TO WHOM PAID</u>	<u>AMOUNT PAID</u>	<u>BALANCE OWED</u>	<u>ACC'T. #</u>
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E. Do you anticipate any changes in income or assets (including real estate ownership) within the next twelve months? (Circle one)

Yes No If yes, explain: _____

F. Do you have any sources of financial support not listed above? (Circle one)

Yes No If yes, explain: _____

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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

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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.