Garden Path Elder Living
Bradley House, Brattleboro, VT

Admissions Contact
802-246-1556
info@gardenpathelderliving.org

Application For Admission

Our residents must meet certain income guidelines, as well as physical ability guidelines, and these forms help us create a full understanding of each applicant. Our Admission Coordinator works closely with our Business Manager and nurses to ensure all steps are completed quickly.

The following documents must be submitted with this application to be complete:

___ Most recent tax return
___ Current bank account statements
___ Medical Release Form
___ Medical Form, filled out and returned by your doctor (including the MOCA)

Please return through fax, postal mail, or hand delivery.
Fax: 802-254-1135
Mail: Bradley House, attn: Admissions, 65 Harris Ave, Brattleboro, VT 05301

After the medical and financial forms have been received, we will contact you to set up an appointment for an assessment with one of our nurses.

Once accepted for admission, a date and time will be scheduled for you to move in. You will be sent a letter detailing all of the information needed prior to admission, and what you need to bring with you that day.

On admission day we will meet with you to complete the AdmissionAgreement, and Permission Forms, and you will receive copies of the Resident Rights and House Rules. The Nurse Manager will meet with you to create and review your personal plan of care, review your medications, and collect any necessary documents.

Garden Path Elder Living Application

Section One: General Information

Date: _____

Resident Name: _____

Phone: (____)_____ Email: _____

Current Street Address: _____

City, State, Zip: _____

Date of Birth: _____/_____/_____ Age: _____

Social Security # _____-_____-_____

Marital Status: Single Married Widowed Divorced Other

Present Living Arrangements: House Apartment Alone With Relatives

Primary Contact for Application Process:

Name: _____ Relationship: _____

Street Address: _____

City, State, Zip: _____

Phone: (_____) _____ Email _____

If the applicant has a Power of Attorney, please list here:

Name: _____ Relationship: _____

Street Address: _____

City, State, Zip: _____

Phone: (_____) _____ Email: _____

Section Two: Financial Information

Please provide the most recent tax return and bank account statements with the application.

Income

Social Security income received monthly: _____

Pension income received monthly: _____

Investment income :_____ per month/quarter year

Other Income: _____

Average Monthly Income from all sources: _____

Assets

Annuities (total): _____

Investments (total): _____

Savings and Checking (combined, all accounts): _____

Estimated Value of Home If Owned: _____

Outstanding Mortgage Amount: _____

Do you plan to sell the home in near future? _____

Additional Assets and Considerations:

Insurance

Do you have a private long-term-care insurance policy? _____

Benefit Description and Terms: _____

Do you have Long-Term Care Medicaid? _____

If you are a Vermont resident, are you enrolled in the Choices for Care program? _____

Additional Health Insurance Information: _____

Additional Financial Contribution

If an additional monthly contribution from family members or other sources should be included, please provide the information and amount here:

By signing this form, I assert that, to the best of my knowledge, this information is accurate.

Signed _____ Date _____
(Applicant or applicant's legal representative)

Section Three: Health and Wellness

1. Are you able to walk without assistance? Yes No
   Are you able to walk with a cane? _____ Walker? _____
   Explain any mobility difficulties:

2. Are you able to bathe without assistance? Yes No
   Explain any bathing difficulties:

3. Are you able to dress without any assistance? Yes No
   Explain any dressing difficulties:

4. Are you able to eat without assistance? Yes No
   Explain any eating difficulties:

5. Are you able to handle all of your own toileting needs? Yes No
   Explain any toileting difficulties:

6. Are you able to transfer yourself from a seated to a standing position? Yes No
   Explain any difficulties with transferring:

7. Do you have a diagnosis of Alzheimer's or Dementia? Yes No
   Explain any difficulties with short-term memory loss:

Please include any other information we should know regarding your care needs, medical condition, and reasons for considering joining us at Bradley House at this time. (If preferred, you may include a separate typed page with this application. Make sure your name and date is clearly stated at the top, and please write "See Attached" in the space below.)

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Physician Contact Information and Medical Release Form (to be filled out by applicant and returned to Garden Path Elder Living.)

Patient Name _____

Patient DOB _____

Primary Care Provider Name: _____

Clinic Name: _____

Street Address: _____

City, State, Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Other Care Provider Name: _____

Clinic Name: _____

Street Address: _____

City, State, Zip: _____

Phone: (_____) _____ Fax: (_____) _____

_____ I have attached additional contact information to this application.

I hereby authorize Garden Path Elder Living to contact and gather information from my primary care physician and other care providers as listed above to assess my care needs in order to determine if I am eligible for admission.

Print Full Name: _____

Signature_____ Date_____
(Applicant or applicant's legal representative)

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Medical Form for Admission (to be filled out by Primary Care Provider and returned to Garden Path Elder Living.)

Please fax both pages of this form, a MOCA assessment, and list of current medications to
Fax: 802-254-1135

Patient Name: _____ Patient DOB: _____

Current Medical Diagnoses and Chronic Conditions (check all that apply and add notes)

Heart Disease ___
Angina ___
CHF ___
Hyper/Hypotension ___
Stroke ___
COPD ___
Asthma ___
Bronchitis ___
Tuberculosis ___
Diabetes ___

Thyroid Disease ___
Kidney Disease ___
UTI ___
Macular Degeneration___
Arthritis ___
Cancer ___
Seizure Disorder ___
GERD ___
Alcohol/Drug Abuse ___
Mental Illness ___
Depression ___

Disabilities and Impairments (check all that apply)

Speech ____ Sight ____ Hearing ____ Cognition ____

Paralysis ____ Incontinence ____ Contracture ____

Page II -- Medical Form for Admission, Garden Path Elder Living

Patient Name _____

Physical Exam: P _____ BP _____ R _____ Weight _____

Skin _____Head/Neck _____

Respiratory _____ Cardiovascular _____

Abdominal _____ Genito/Urinary _____

Skeletal/Joints _____Glandular _____

Neuromuscular _____PPD results _____

Has the applicant suffered any serious illness or been hospitalized in the past 5 years?

Allergies or special diets:

Physician Signature _____Date _____

Printed Name _____

Clinic Name and Location:_____

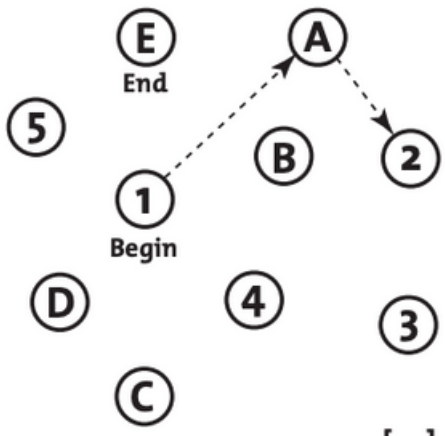
Please fax both pages of this form, a MOCA assessment, and a list of current medications to:

Fax: 802-254-1135

MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME :
Education : Date of birth :
Sex : DATE :

VISUOSPATIAL / EXECUTIVE



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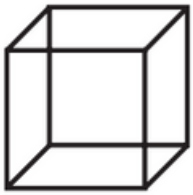


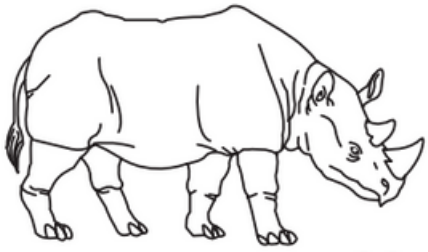
[ ] [ ]

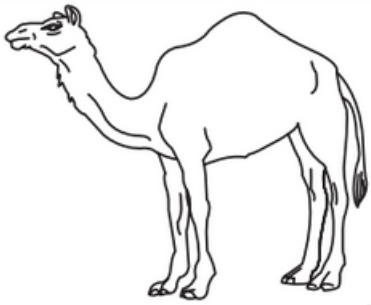
Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS ___/5

NAMING





[ ] [ ] [ ] ___/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION

Read list of digits (1 digit/ sec.).
Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2 ___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B ___/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt** ___/3

LANGUAGE

Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ] ___/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words) ___/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler ___/2

DELAYED RECALL

	Has to recall words WITH NO CUE	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

___/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City ___/6

 Version November 7, 2004

Normal ≥ 26 / 30

TOTAL ___/30

Add 1 point if ≤ 12 yr edu

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