Garden Path Elder Living
Bradley House, Brattleboro, VT

Admissions Contact
Tel. 802-246-1556
Fax. 802-254-1135
info@gardenpathelderliving.org

65 Harris Avenue, Brattleboro, VT 05301 www.GardenPathElderLiving.org

Application for Admission

Garden Path Elder Living welcomes new resident applications from all backgrounds who are aged 65 and over, are ambulatory and who meet Vermont Residential Care III guidelines. This application helps us create a full understanding of each applicant. Our Admissions team works closely with our business office and nursing team to ensure all steps are thoroughly completed.

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

- Financial information: recent tax return, bank & asset statements indicating ability to meet monthly rental agreement for three years
- Medical Release Form
- Medical information: Recent (<90 days) doctor visit summary, current medications list, diagnoses and a completed MOCA test

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

After the medical and financial forms have been received, and a background check satisfactorily completed, Admissions will contact you to set up an appointment for an in-person assessment with our Clinical Director.

Once accepted for admission, a date and time will be scheduled for you to move in. You will be sent a copy of the Admissions Agreement and helpful information prior to your admission, including what you need to bring with you on your move-in day.

On admission day, we will meet with you to complete the Admission Agreement and permission forms. You will receive copies of the Resident Rights and a schedule of Activities and meal times at Bradley House. The nurse will meet with you to review and create your personal care plan, review your medications, and collect any necessary documents.

Our rates include room, board, activities, media (Wi-Fi and cable) and resident care. Garden Path Elder Living offers three tiers of care level according to Vermont State Residential Care III Home guidelines. All residents enter the Home at Level II care and are reassessed by the Clinical Manager to determine a more accurate level of care based on the new resident's realized needs. Care Plan assessments are conducted annually or as needed, such as if there is a prolonged change in health status observed by care staff.

2026/2027 rental rates are listed below:

2026/2027	Single Room Monthly Rate	Per Day	Suite Monthly Rate	Per Day
Tier 1	$6,575.00	$215.57	$9,375.00	$307.38
Tier 2	$7,350.00	$240.98	$10,150.00	$332.79
Tier 3	$8,225.00	$269.67	$10,995.00	$360.49

An entrance fee of $1,500.00 is due at the time a reservation to move in is made. A reservation fee of the room rent plus half the cost of care applies following successful assessment until selected move in date.

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Garden Path Elder Living Application

Applying for: ☐ Residential Care ☐ Respite Stay ☐ Hospice Care

Section One: General Information

Application Date: _____

Resident Name: _____

Phone: (____) _____ Email: _____

Current Street Address: _____

City, State, Zip: _____

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

Military Service: Yes/ No What Branch? _____ Service Dates?_____

Present Living Arrangements: ☐ House ☐ Apartment ☐ Other

☐ Alone ☐ With Family/ Next Friends ☐ Roommate or Caregiver

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced

Significant Other's Name: _____ Contact:_____

Sex: Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say ☐

Preferred Pronouns: _____

Primary Contact for Application Process:

Name: _____ Relationship: _____

Street Address: _____

City, State, Zip: _____

Phone: (_____) _____ Email _____

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If the applicant has a Power of Attorney, please list below. Please provide copies of all legal documents including POAs and Advanced Directives on Admission Day (Power of Attorney & Guardianships).

Healthcare POA: _____ Relationship: _____

Mailing Address: _____

Phone: (_____) _____ Email: _____

Financial POA: _____ Relationship: _____

Mailing Address: _____

Phone: (_____) _____ Email: _____

Legal Guardian: _____Over Person ____Over Estate/ Finances _____Both

Name: _____

Mailing Address: _____

Phone: (_____) _____ Email: _____

Emergency Contact: ☐HC-POA ☐ F-POA ☐ Guardian

Name: _____ Relationship:_____

Mailing Address: _____

Phone _____Phone(W)_____Email: _____

Physician/ Medical Information:

Primary Care Physician:_____Location:_____

Other Physician/ Medical Information:

Physician:_____Location:_____

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Section Two: Financial and Insurance Information

Please provide income information demonstrating ability to pay rental rates for three years or proof of Vermont Medicaid programs Choices for Care and ACCS. You may include copies of a long-term care insurance policy, the most recent tax return and bank account statements in support of your application.

Income

Social Security income $ _____ monthly / yearly

Retirement income $ _____ monthly / yearly

Investment income: $_____ month/quarter/year

Other Income: $ _____ monthly / yearly

Average Income from all sources: $ _____ monthly / yearly

Assets

Savings Account(s) Total $_____ Checking

Account(s) Total $_____

Stocks $_____ Bonds $_____

CDs $_____ 401K $_____

IRA $_____ Trusts $_____

Annuity $_____ Mutual Funds $_____

Real Estate Owned Total $_____

Outstanding Mortgage Amount: _____

Do you plan to sell the property in near future? _____Approx. Value_____

Additional Assets and Considerations:

_____

_____

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Insurance

Do you have a private long-term-care insurance policy? Yes ☐ No ☐

Details:_____

Do you have Long-Term Care Medicaid? Yes ☐ No ☐

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 or attach separately:

_____

_____

_____

_____

_____

_____

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Section Three: Health and Wellness

1. Are you able to walk without assistance? Yes ☐ No ☐

2. Are you able to walk with a cane? _____ Walker? _____
Explain any mobility difficulties:

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

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

5. Are you able to eat without assistance? Yes ☐ No ☐
Explain any eating difficulties or special diets:

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

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

8. Do you have a diagnosis of Alzheimer's or Dementia? Yes ☐ No ☐
Explain any limitations 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 page with this application. Make sure your name and date are clearly stated at the top, and please write "See Attached".)

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Physician Contact Information and Medical Release Form

Information to be filled out by applicant, requested from your medical provider and submitted to Garden Path Elder Living. Please send a recent (<90 days) electronic medical visit summary, current medications list and list of diagnoses FAO Clinical Manager, to fax 802-254-1135

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 to best determine if I am eligible for admission.

Print Full Name: _____

Signature_____Date_____

(Applicant or applicant's legal representative)

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By signing this form, I assert that, to the best of my knowledge, the information I have supplied is accurate. I understand that any deliberate misrepresentation of the information presented in this application could result in rejection of my application or discharge from Garden Path Elder Living.

Signed _____ Date _____
(Applicant)

Print _____

Signed _____ Date _____
(Applicant's legal representative)

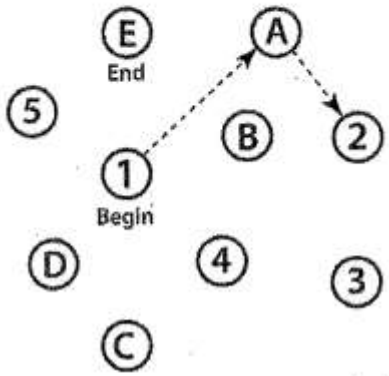
Print _____

MONTREAL COGNITIVE ASSESSMENT (MOCA®)

Version 8.1 English

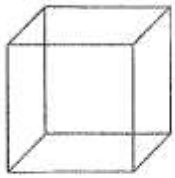
Name:
Education: Date of birth:
Sex: DATE:

VISUOSPATIAL/EXECUTIVE



[ ]

Copy cube



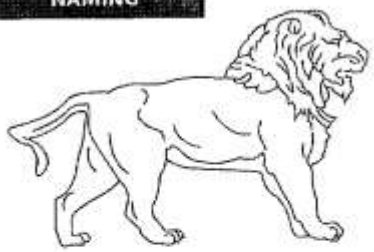
[ ]

Draw CLOCK (Ten past eleven)
(3 points)

[ ] Contour [ ] Numbers [ ] Hands

POINTS __/5

NAMING



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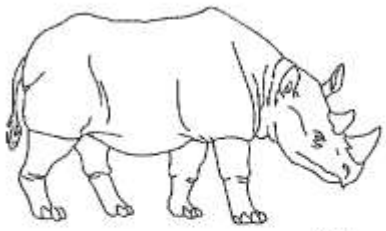

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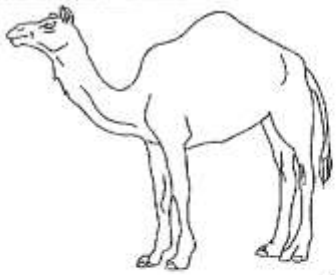

[ ]

__/3

MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. 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**

__/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. orange - banana = fruit [ ] train - bicycle [ ] watch - ruler

__/2

DELAYED RECALL

Memory Index Score (MIS)

(MIS)	Has to recall words WITH NO CUE	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
X3		[ ]	[ ]	[ ]	[ ]	[ ]	
X2	Category cue						MIS = ____/15
X1	Multiple choice cue						

__/5

ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

__/6

www.mocatest.org

Administered by: _____

Training and Certification are required to ensure accuracy

MIS: /15
(Normal ≥ 26/30)
Add 1 point if ≤ 12 yr edu

TOTAL __/30