



1200 North Avenue Burlington VT 05408  
(P)802-658-1573 (F)802-864-0930  
Admin@ethanallenresidence.com

## ADMISSION APPLICATION

Resident admissions to Ethan Allen Residence are accepted Monday through Friday, between 9am and 2pm. Weekend and holiday admissions are not accepted. Please provide the requested information below in order for your application to be processed. All necessary documents and medications must be in-house prior to admission.

\_\_\_\_\_  
Resident Name

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Marital Status

\_\_\_\_\_  
Mother's Maiden Name (required by State of VT)

\_\_\_\_\_  
Father's Full Name

\_\_\_\_\_  
Date of Admission

\_\_\_\_\_  
Admitted From (include address)

Medicare #: \_\_\_\_\_

Other Insurance Information: \_\_\_\_\_  
\_\_\_\_\_

For Veteran's Only: Are you eligible for TRICARE (formerly CHAMPUS)? \_\_\_\_\_

Primary Physician

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Address



**Legal Financial Representative:**

\_\_\_\_\_  
Name Relationship Home Phone  
\_\_\_\_\_  
Address Other Phone

**Legal Health Care Representative:**

\_\_\_\_\_  
Name Relationship Home Phone  
\_\_\_\_\_  
Address Other Phone

**Power of Attorney:**

\_\_\_\_\_  
Name Relationship Home Phone  
\_\_\_\_\_  
Address Other Phone

**Emergency Contact:**

\_\_\_\_\_  
Name Relationship Home Phone  
\_\_\_\_\_  
Address Other Phone

\*Choices for Care eligibility is determined by the state of Vermont, Medicaid waiver program. Eligibility and availability cannot be predicted or guaranteed.

**To the best of my knowledge the information provided is accurate and true. I do not hold Ethan Allen Residence, it's staff or affiliates responsible for any consequences, financial or otherwise, as a result of inaccurate or incomplete information on this form.**

\_\_\_\_\_  
Signature of Resident or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Resident or Responsible Party

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## FINANCIAL DISCLOSURE

Ethan Allen Residence endeavors to provide quality care to all our residents. Part of this care is ensuring there is a clear understanding of financial responsibilities of the resident and his/her responsible party. As you know, the care associated with providing assisted living services is costly and time consuming. We want to be assured that you understand your financial responsibilities and that you have the means to meet it.

**This information will be kept strictly confidential**

Resident Name : \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

### **Responsible Party** (Individual responsible for paying bills, POA, Self, other)

Name \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Relationship to Resident \_\_\_\_\_ Email \_\_\_\_\_

Medicare # Part A \_\_\_\_\_ Part B \_\_\_\_\_  
Other Insurance \_\_\_\_\_ Policy # \_\_\_\_\_  
\_\_\_\_\_ Policy # \_\_\_\_\_  
Long Term Care Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

### **Income/Assets**

Retirement/Pension \$ \_\_\_\_\_ Rental Income \$ \_\_\_\_\_  
Other Income \$ \_\_\_\_\_ Annuities/Investments \$ \_\_\_\_\_  
Does Resident own his/her own home? Yes \_\_\_ No \_\_\_ Approximate Value \$ \_\_\_\_\_  
Value of other real estate assets \$ \_\_\_\_\_  
Value of other assets \$ \_\_\_\_\_

### **Method of Payment** (please check all that apply)

Private Pay \_\_\_\_\_ Private Insurance \_\_\_\_\_ SSI \_\_\_\_\_  
Enhanced Residential Care (Community Medicaid) \_\_\_\_\_ Other \_\_\_\_\_

Has the resident applied, or will be applying, for State Medicaid Assistance?

Yes \_\_\_\_\_ No \_\_\_\_\_ Medicaid Number \_\_\_\_\_

If Private Pay, how long do you anticipate being private pay?

0-6 month\* \_\_\_\_\_ 7 – 12 months\* \_\_\_\_\_ 13 – 24 months\* \_\_\_\_\_  
25 – 36 months \_\_\_\_\_ 36 – 48 months \_\_\_\_\_ 49+ months \_\_\_\_\_

\* Choices for care eligibility is determined by the State of Vermont, Medicaid Waiver Program eligibility and availability cannot be predicted or guaranteed.

I hereby state that, to the best of my knowledge, the above information given is accurate and true. If any of this information has been falsely represented, I understand that is sufficient grounds to terminate this application for admission. I agree to promptly communicate any financial changes to Mary Belanger, the administrator, so that alternate arrangements may be made as necessary.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Party  
(POA/Guardian)

\_\_\_\_\_  
Date

To help ensure the confidentiality of this application, please return to:

Ethan Allen Residence  
1200 North Avenue  
Burlington VT 05408

in a sealed envelope addressed to Admission's Coordinator.



1200 North Avenue Burlington VT 05408  
(P)802-658-1573 (F)802-864-0930  
Admin@ethanallenresidence.com

**CONFIDENTIAL MEDICAL INFORMATION RELEASE AUTHORIZATION**

**TO:** \_\_\_\_\_  
(Name of Physician or other person(s) receiving release authorization)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Fax

*I hereby authorize you to release to Ethan Allen Residence any information including diagnosis, medical records, treatments or examinations rendered to me while under your care.*

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Signature of Patient or Person Authorized to Consent for Patient

\_\_\_\_\_  
Date

*If Consenter used, please print name, address and phone number:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Confidentiality Notice**

This facsimile contains PRIVILEGED and CONFIDENTIAL information intended only for the use of the addressee(s) named above. If you have received this facsimile in error you are requested to destroy all documents. Thank you.