Our Lady of Providence (VT), Inc.
47 West Spring Street
Winooski Vermont 05404
(802) 655-2395
Application for Residency

NAME: Last First Middle Initial
Mr. Mrs. Miss. _____ _____ ___

Your current address (where you live): _____

Give last place of residence and date: City State Date
_____ _____ _____

Phone:_____

Marital Status: _____is spouse living? _____Date of death:

Spouse's Name _____ Spouse's Birthdate ___/___/_____

Age: _____Date of Birth: ____/____/_____ Place of Birth: _____

Father's Name: _____ Place of Birth _____

Mother's Maiden Name: _____Place of Birth_____

Family Physician: _____ Telephone (____) _____-_____
Address:_____

Social Security#:___-___-_____ Medicare #: _____

Do you have a Medicare Supplemental Policy? Yes_____ No_____If Yes, please name the company and provide us with the Medicare Supplemental Policy # _____

Do you carry other health insurance? Yes ___No___

Name of Company_____

Group #: _____Certificate #_____

Do you have anyone who aids you with your financial matters? Yes_____ No_____

Name _____Address _____ Tel. No. (___) ___-_____ Relationship _____
Name _____Address _____ Tel. No. (___) ___-_____ Relationship _____

Who would be responsible for paying for your costs of staying at Our Lady of Providence?

Name	Name	Name
Address	Address	Address
City	City	City
State ____ Zip code_____	State ____ Zip code_____	State _____ Zip code_____
Telephone (____) ____-_____	Telephone (____) ____-_____	Telephone (____) ____-_____
Email	Email	Email

Do you have Long Term Care Insurance that would cover (or partially cover) the cost of your living at Our Lady of Providence?

Yes_____ No_____ If you answered Yes, what company do you have your Long-Term Care Insurance with?

Company Name_____ Policy Number_____

Please describe your Long-Term Care Coverage: Amount covered per day:_____,

Maximum Amount of Time that your LTC policy will cover your stay: _____.

Who would you like to have notified in case of emergency?

Name	Name	Name
Address	Address	Address
City	City	City
State _____ Zip code_____	State _____ Zip code_____	State _____ Zip code_____
Telephone (____) ____-_____	Telephone (____) ____-_____	Telephone (____) ____-_____
Mobile (____) ____-_____	Mobile (____) ____-_____	Mobile (____) ____-_____

Nearest Relative now living:
Name _____Address _____ Tel. No. (___) ___-_____ Relationship _____

Do you have: An Advanced Directive for your health care decisions? Yes _____ No _____

Do you have: Durable power of attorney? Yes____ No___

Have you ever been a resident in any other home, assisted living facility or nursing home? Yes or No

If yes,

Name _____Address _____ Length of Stay___

Reason for leaving_____

Church Preference: _____

Do you observe any special practices? _____

Do you have a preferred Funeral Director?_____

Address & Phone Number for Preferred Funeral Director_____

Do you have any medical problems or physical disabilities: Yes _____ No _____?

Describe: _____

_____

_____

_____

_____

Do you take any medications regularly? If, yes please list then and include those prescribed by a doctor and those taken over the counter, such as Tylenol or vitamins:

_____

_____

_____

_____

Do you have any hobbies or special interests?

Are there any special wishes that would make your stay here more enjoyable?

Are there any new areas of interest you would like to pursue during your stay?

The 2025 rates for Our Lady of Providence Residential Care Facility are:

Residential Independent Level	$258.10 per day	Level I
Residential Care	$322.76 per day	Level II
Residential Care	$404.37 per day	Level III

Higher Levels of care may be determined, and the rates are higher. Your required Level of Care will be determined by the Director of Nursing for Our Lady of Providence prior to Admission.

All exceptions (or addendums) to the level of care determination will be noted and documented in an "Admission Agreement", which shall be signed by Our Lady of Providence's Administrator and the Applicant or his/her legal representative.

OLP may accept SSI payments for monthly Room & Board charges. We do so only on a case-by-case basis, and solely within our discretion. If OLP does decide that it will accept SSI as payment there will be an addendum to your contract which will state: The amount of SSI payment, the room and board rate, the amount of personal needs allowance and a date that addendum is in effect for. However, OLP will expect family members who can contribute to your care to do so. Because we are a non- profit, public charity, we depend on contributions to meet our charitable mission of providing care to those who need it.

OLP may accept ACCS payments for monthly nursing services fees. We do so only on a case-by-case basis, and solely within our discretion. If OLP does decide that it will accept ACCS as payment there will be an addendum to your contract which will state: The amount of ACCS payment, the level of service provided and the date that the addendum is in effect for. When we do accept ACCS payment, it results in a significant gap between what OLP is paid for the cost of care and the actual cost of care to the applicant. Accordingly, we expect family members to volunteer at OLP and to aid OLP in Fundraising activities to help us close that gap.

OUR LADY OF PROVIDENCE RESIDENCE
47 West Spring Street
Winooski, Vermont

ADMITTING PHYSICIAN'S STATEMENT

Patient Name: DOB

Attending Physician: Phone
Address for Attending Physician's Office: _____

Allergies:
1.
2.
3.
4.
Diagnosis:

Diet:
Treatment: _____
Activity level: (i.e., walker, cane, stairs, W/C bathing):

Other data:
How often do you see this person:
_____

Physician's signature:
Please return this signed form with a copy of your most recent physical exam and relevant notes from your file with your physician. All will be included in your medical chart.

THIS SECTION SHOULD BE COMPLETED BY THE PROSPECTIVE RESIDENT OR PROSPECTIVE RESIDENT'S FAMILY. THIS PAGE IS REQUIRED TO BE COMPLETED FULLY AND ACCURATELY BEFORE OLP WILL BE ABLE TO PUT YOU ON THE OLP WAITING LIST

Monthly Income Statement for (insert name):
Social Security $_____
Retirement/Pension
$ _____
$_____
Rental Income $_____

Annuities/Investments
$_____
$_____
Other (List all other income or sources of Money or Assets you have to pay your expenses)
$_____

Real Estate Assets:_____
_____

Do you own your own Home or have any interest in any real estate (including any camps or seasonal properties)? Yes, _____No _____ Approximate Value $

If any of the above listed property is jointly owned with others, then name those co-owners:_____
_____

Life Insurance
Company Name Approximate Value $_____
Annuities:
Company Name Approximate Value $_____

Other Assets/Investments (stocks, bonds, IRAs) $_____
Total of fixed monthly debts/payments $_____
List any major credit cards $_____
Cash assets in banks, credit unions, savings and financial institutions:
Institution Name:
Address:
Balance in Account $_____
Names listed on Account
Institution Name:
Address:
Balance in Account $_____

Have you owned any property within the last five years that you have not already included in this financial disclosure, including any real estate, any investment accounts, savings and/or checking accounts, cars, furnishings with a total value more than $2,000, or any other assets that have a total combined value more than $2,000? Yes____No_____ If yes, describe the property_____

_____

If yes, what would happen to that property and those assets if it was not spent down to help offset the cost of your care?

I hereby state to the best of my knowledge and belief that the above financial statement is true, correct and complete. I understand that if any information has been falsely represented, that this will be cause for voiding
my application for admission, or cause for discharge after admission to OLP.

Signature of Resident:_____
Date:_____

Signature of Family Member handling Resident's financial concerns_____

Print Name:_____
Date:_____

Address_____
_____

Are you a court-appointed Guardian for the resident? Yes _____No_____

Do you have Power of Attorney for the Resident? Yes_____ No_____

Medical Information Release Form - UVMMC

I, _____DOB:_____give permission for
Resident Name
the Director of Health Services at Our Lady of Providence Residential Care Facility to access my medical record electronically through PRISM at UVMMC. Access to all available and pertinent records is granted and this information will be used for the sole purpose of determining if I am a likely candidate for placement at this residential care facility.

Patient Signature:_____

Date:_____
(Authorized representative if patient unable to sign)

Medical Information Release Form

I, _____DOB: _____request all
Resident Name
pertinent medical information, as requested below, be forwarded to Our Lady of Providence in anticipation of possible residency in the community.

Specifically, I request Dr. _____provide the following information to the Director of Health Services: notes from last office visit, current problem list, comprehensive medication list and a copy of my COLST as on file.

All information may be faxed to, Director of Health Services at 655-3888.

Patient Signature:_____

Date:_____
(Authorized representative if patient unable to sign)

Our Lady of PROVIDENCE
RESIDENTIAL CARE FACILITY

2025 Room Rates

Daily Room Rates

Level 1 Care	$258.10
Level 11 Care	$322.76
Level 111 Care	$404.37

Daily room rates include room, board, and nursing services.

Monthly Charges

Cable $48.40

Telephone $20.50

Our Lady of Providence Vt., Inc. 47 West Spring Street Winooski, Vt. 05404

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