



## **Application for Residency**

**Craftsbury Community Care Center**

1784 East Craftsbury Road · Craftsbury, Vermont 05826

Telephone: (802) 586-2414 · Fax: (802) 586-6956

Website: [www.craftsburycommunitycarecenter.org](http://www.craftsburycommunitycarecenter.org) Email: [ccccenter@myfairpoint.net](mailto:ccccenter@myfairpoint.net)

*Equal Housing Opportunity*

<b>I. General Information</b>			
Application Name:		Social Security #:	
Address:			
City:		State:	Zip Code:
How many years at this address?		Date of Birth: (month/day/year)	
Telephone Number:		Sex: (male or female)	
Birthplace:		Occupation:	
Marital Status: (married, single, windowed, or separated)			
Do you handle your own business affairs? (yes or no)			
If no, who handles your finances for you? (name, address and telephone number)			
Do you have a power of attorney? (yes or no)			
If so, please list your power of attorney: (name, address and telephone number)			
Preferred date of admission:			
<b>II. Current Living Conditions</b>			
What type of housing are you in now? (apartment, condo, home, community living, nursing home, other)			
Do you currently own your home or rent?			
Is there a lien on your property? (yes or no)			
If yes, who is your mortgage with? Please list mortgage company, address and phone number.			
Do you live alone or with family/friend?			

If you live with someone, please list their name and phone number.	
Do you require someone to visit you during the day? If so, please list their name(s) and phone number.	
Do you own an automobile? (yes or no)	Do you drive yourself regularly? (yes or no)
Do you still have payments on your automobile? (yes or no)	If so, what are your payments per month?
<b>III. Medical Information and Insurance</b>	
Primary Physician's Name:	Primary Physician's Telephone:
Primary Physician's Address: (city, state, and zip code)	
How would you describe your current health?	
When was your last doctor's visit?	
What are your medical diagnoses?	
Please list any medications that you are taking at the present time:	
Do you require assistance to administer the medication? (yes or no)	
Please list any outside services that come in to help you (such as Home Health):	
Do you prepare your own meals? (yes or no)	
If you are on a special diet, please describe:	
Please list any special equipment that you use (such as a cane, walker or wheel chair):	
Do you have Medicare? (yes or no)	Do you have Medicaid? (yes or no)
Please list your medical insurance coverage (insurance companies and policy numbers), including supplemental and long-term care:	

**IV: Income**

List all income from all sources, including but not limited to wages/salary, welfare, social security, veteran's pension, interest, annuities, dividends, proceeds from rental property, 401K, or IRA:

Source	Amount Received	How Often	Name & Address

How many people (in total) live on your income?

**Assets**

List all bank accounts including savings and checking, stocks and bonds, CD's, cash value of life insurance, and all other assets including real estate, 401, IRA with copies of federal and state income tax.

Type of Asset	Current Value (\$)	Account #	Name & Address (to verify)

<b>Expenses</b>			
List all expenses you pay on a regular basis (rent, car payments, household expenses, etc).			
<b>Name &amp; Address to Whom Paid</b>	<b>Amount Paid</b>	<b>Balance Owed</b>	<b>Account #</b>
Do you anticipate any changes in income and assets (including real estate ownership) within the next 24 months? (yes or no)			
Please describe any sources of financial support (not listed above):			

The information on this form is to be used by the Craftsbury Community Care Center, Inc. and its agents to assist in determining the eligibility of the applicant for residency at the Center and which services may be required. We are required by our funding sources to document the eligibility of residents, and for this reason, 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. Omissions of income, assets or expenses will result in termination of the Admission Agreement.

\_\_\_\_\_  
Signature of applicant                      Date

\_\_\_\_\_  
Signature of legal representative                      Date

\_\_\_\_\_  
Printed name of applicant

\_\_\_\_\_  
Printed name of legal representative

*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.*



**Application for Residence  
Release Form**

Dear Sir or Madam:

The person identified below has applied for residency, or is being re-evaluated for continued residency, at Craftsbury Community Care Center a residential care home. 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 purposes described above.

Thank you for your consideration.

Sincerely,  
*Kimberly Roberge*  
Executive Director

**RELEASE FORM**

Name:		Social Security #:	
Mailing Address:			
Legal Address:			
I hereby authorize Craftsbury Community Care Center, Inc. and its agents to contact any individuals, agencies, offices, groups or organizations to obtain any information or materials deemed necessary to verify my suitability or eligibility for residence and services which I may require at the Center. I further authorize any of those contacted to release the information requested to Craftsbury Community Care Center, Inc. and its agents.			
Signature:		Date:	

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