



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.



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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.

2024/2025 rental rates are listed below:

2024/25	Single Room Monthly Rate	Per Day	Suite Monthly Rate	Per Day
Tier 1	\$5,900.00	\$193.44	\$8,825.00	\$289.34
Tier 2	\$6,620.00	\$217.05	\$9,545.00	\$312.95
Tier 3	\$7,450.00	\$244.26	\$10375.00	\$340.16

An entrance fee of \$1,000.00 is due at the time a reservation to move in is made. A reservation fee of the room rate plus half the cost of care applies following successful assessment until selected move in date. For a resident entering at Tier 2 care, this would equal approximately \$100.66 per day at 20024/25 rate schedule.



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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: \_\_\_\_\_

Gender Identity: 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:  
Sex:

Date of birth:  
DATE:

**VISUOSPATIAL / EXECUTIVE**

Copy cube

Draw CLOCK ( Ten past eleven )  
(3 points)

**POINTS**

[ ]
[ ]
[ ]
[ ]
[ ]
[ ]
[ ]

Contour
Numbers
Hands

\_ / 5

**NAMING**

[ ]

[ ]

[ ]

\_ / 3

MEMORY	FACE	VELVET	CHURCH	DAISY	RED	NO POINTS
Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.	1 <sup>ST</sup> TRIAL					
	2 <sup>ND</sup> TRIAL					

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

\_ / 5

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

\_ / 6