The Harry and Jeanette Weinberg Park Assisted Living
Application for Admission

1. Name _____ Maiden Name : _____
2. Address _____ Social Security #_____
_____ Telephone # _____

3. Sex M _____F _____ Present Age _____ Birth date _____
4. Marital Status _____ # of Surviving Children _____

5. Names of living relatives or Friends (Circle 2 to be notified in case of emergency)

A. Name _____ B. Name _____
Relationship_____ Relationship _____
Address _____ Address _____
_____ _____
Phone # Home _____ Phone # Home _____
Work _____ Work _____
Cell _____ Cell _____

6. Occupation and Employment:

a. Usual Occupation or Profession : _____
b. Employer Name :_____
c. Date of Retirement : _____
d. Veteran: Yes _____ No _____ Branch of Service: _____

7. General Information:

A. What is the intention of your requested admission:
Long Term: _____ Remainder of Life: _____ Respite: _____

B. Does a "Power of Attorney" exist for the applicant? Yes _____ No _____
If yes, what type and who holds: (a copy must be provided to Weinberg Park)
General Power of Attorney: _____
Durable Medical Power of Attorney _____
Limited Power of Attorney: _____
Living Will: _____

Advanced Directive: _____
Name of person holding or responsible for documents: _____
Address: _____
Phone# _____

C. If no, please list who handles the affairs of the applicant in priority:

1. Name: _____ 2. Name: _____
Address: _____ Address: _____
_____ _____
Phone# _____ Phone# _____

8. Financial Summary:

A. Present Monthly Income:

Social Security:	$ _____
Private pension	$ _____
Vet's Pension	$ _____
Other	$ _____
	$ _____
	$ _____
Total:	$ _____

B. Present Monthly Income from Investments:

Investment	Monthly Int/Div	Annual Total
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Please list all bank accounts:

Name and Address of Bank:	Account#:
_____	_____
_____	_____
_____	_____
_____	_____

C. Please list all stocks, Bonds and other similar assets:

Name	#of Shares	Present Market Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Real Estate: List all properties owned by the applicant:

_____

_____

_____

What is the applicant/applicant's family intentions regarding the above properties?

_____

_____

E. Have any assets been transferred or sold from ownership of the applicant to any other persons within the past 36 months? Yes _____ No _____

If yes, please list completely:

_____

_____

_____

F. Are any assets jointly owned between the applicant and other parties or individuals? Yes _____ No _____

If yes, please list completely:

_____

_____

G. Have any deeds to property been transferred or sold from ownership of the applicant to any other persons in the last 36 months? Yes _____ No _____
If Yes, Please list completely:

Assets	Present Market Value
_____	_____
_____	_____
_____	_____

I. Do any life estates, trusts, or similar documents exist which may have an impact on the applicant? Yes _____ No _____

J. Does the applicant have any debts or obligations? Yes _____ No _____
If so, please specify

_____
_____
_____

9. Burial Arrangements:

A .Mortician: _____
Address: _____
Phone#: _____
B. Person Responsible for Funeral Arrangements:
Name: _____ Relationship: _____
Phone#: Home _____ Work _____
Cell _____

10. Health Insurance Information:

A. Medicare # _____
B. BC/BS # _____
C. Other Name: _____
Number: _____

D. Medical Assistance:
Does the applicant currently have medical assistance? Yes_____ No____
If yes, what type, and number:
Community MA: _____
Long Term Care: _____
Other: _____
If no, have you applied: Yes _____ No _____
If yes, what was applied for? _____
When? _____
Caseworker Name & Phone# _____

According to my knowledge and belief, the foregoing information is true and accurate. I understand that all pertinent information but not limited to medical and financial matters

must be disclosed fully whether specifically requested or not. I agree to abide by all rules and regulations, policies and procedures of Weinberg Park, if admitted.

Signature of Applicant or person acting for applicant	Date

Resident Name_____
Date of Birth_____ Date Completed_____

HEALTH CARE PRACTITIONER RESIDENT PHYSICAL ASSESSMENT FORM

This form is to be completed by a physician, certified nurse practitioner, registered nurse, or certified nurse mid-wife. Questions noted with an asterisk are "triggers" for awake overnight staff. The practitioner completing this form must review the Resident Assessment Scoring Tool.

Please note the following before filling out this form: Under Maryland Regulations an assisted living program may not provide services to an resident who at the time of initial admission, as established by the initial assessment, requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4)Skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is a presence of, or risk for, a fluctuating acute condition; (5) Monitoring of a chronic medical conditions that is not controllable through readily available medications and treatments; (6) Treatments for an active reportable communicable disease; or (7)Treatment for a disease or condition that requires more than contact isolation. Exceptions to the conditions listed above are provided for residents who (a) are in a specialized program for HIV/AIDS which the Department has approved, or (b) are under the care of a licensed general hospice program.

1.* Current Medical and Psychiatric History. [Briefly describe recent change in health or behavioral status, suicide attempts, hospitalizations, falls, etc., within the past six months.

2.* Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, physical, functional, and psychological condition changes over the years.

3. Allergies. List any allergies or sensitivities to food, medications, or environmental factors, and if known, the nature of the problem (e.g., rash, anaphylactic reaction, GI symptom, etc.). Please enter medication allergies here and also in Item 12 for medication allergies.

4. Communicable Diseases. Is the resident free from communicable TB and any other active reportable airborne communicable disease(s)?
(Check one) ___Yes ___No If "No", then indicate the communicable disease:_____
Which tests were done to verify that the resident is free from active TB:
PPD Date_____ Result_____mm
Chest X-Ray (if PPD positive or unable to administer a PPD) Date_____ Result_____

Resident Name_____
Date of Birth_____ Date Completed_____

5. History. Does the resident have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc?

(a) Substance: OTC, non-prescription medication abuse or misuse.
1. Recent (within the last 6 months) ❑ Yes ❑ No
2. History ❑ Yes ❑ No

(b) Abuse or misuse of prescription medication or herbal supplements
1. Currently ❑ Yes ❑ No
2. Recent (within the last 6 months) ❑ Yes ❑ No

(c) History of non-compliance with prescribed medication
1. Currently ❑ Yes ❑ No
2. Recent (within the last 6 months) ❑ Yes ❑ No

(d) Describe misuse or abuse:_____

6.* Risk factors for falls and injury. Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply):
❑ orthostatic hypotension ❑ osteoporosis ❑gait problem ❑impaired balance ❑ confusion ❑ Parkinsonism ❑ foot deformity ❑ pain ❑ assistive devices ❑ other (explain)_____

7.* Skin condition(s). Identify any current or history of ulcers, rash, skin tears with any standing treatment orders also note in Item 12(c), easy bruising, etc., and their causes:_____

8.* Sensory impairments affecting functioning. (Check all that apply)

(a) Hearing: Left ear: ❑ Adequate ❑ Poor ❑ Deaf ❑ Uses corrective aid
Right ear: ❑ Adequate ❑ Poor ❑ Deaf ❑ Uses corrective aid

(b) Vision: ❑ Adequate ❑ Poor ❑ Uses corrective lenses ❑ Blind (check all that apply) - ❑ R ❑ L

(c) Temperature Sensitivity: ❑ Normal ❑ Decreased sensation to: ❑ Heat ❑ Cold

9. Current Nutritional Status. Height_____inches Weight_____lbs.

(a) Any weight change (gain or loss) in the past 6 months? ❑ Yes ❑ No

(b) How much weight change? _____lbs. in the past ____months (check one) ❑ Gain ❑ Loss

(c) Monitoring necessary? (check one) ❑ Yes ❑ No
If items (a), (b), or (c) are checked, explain how and at what frequency monitoring is to occur:_____

(d) Is there evidence of malnutrition or risk for undernutrition? ❑ Yes ❑ No

(e)* Is there evidence of dehydration or a risk for dehydration*? ❑ Yes ❑ No

(f) Monitoring of nutrition or hydration status necessary? ❑ Yes ❑ No
If items (d) or (e) are checked, explain how and at what frequency monitoring is to occur:_____

(g) Does the resident have medical or dental conditions affecting: (check all that apply)
❑ Chewing ❑Swallowing ❑ Eating ❑ Pocketing Food ❑ Gastronomy Tube Fed

(h) Note any special therapeutic diet (e.g., sodium restricted, renal, calorie, or no concentrated sweets restricted):_____

(i) Modified consistency (e.g., pureed, mechanical soft, or thickened liquids):_____

(j) Is there a need for assistive devices with eating (check all that apply): ❑ Yes ❑ No
❑ Weighted Spoon or built up fork ❑Plate Guard ❑ Special cup/glass

(k) Monitoring necessary? (check one) ❑ Yes ❑ No
If items (g), (h) or (i) are checked, please explain how and at what frequency monitoring is to occur:_____

Resident Name_____
Date of Birth_____ Date Completed_____

10.* Cognitive/Behavioral Status.

(a)* Is there evidence of dementia? (check one) ❑ Yes ❑ No

(b) Has the resident undergone an evaluation for dementia? ❑ Yes ❑ No

(c)* Diagnosis (cause(s) of Dementia) ❑ Alzheimer's Disease ❑ Multi-infarct/Vascular ❑ Parkinson's Disease ❑ Other_____

(d) Mini-Mental Status Exam (if tested) Date_____ Score_____

10(e)* Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details.

Item 10(e)	A	B*	C*	D*	Comments
			Cognition		
I. Disorientation	Never	Mild	Moderate	Severe	
II. Impaired recall (recent/distant events)	Never	Occasional	Regular	Continuous	
III. Impaired Judgment	None	Mild	Moderate	Severe	
IV. Hallucinations	Never	Occasional	Regular	Continuous	
V. Delusions	Never	Occasional	Regular	Continuous	
			Communication		
VI. Receptive/Expressive Aphasia	None	Mild	Moderate	Severe	
			Mood and Emotions		
VII. Anxiety	Never	Occasional	Regular	Continuous	
VIII. Depression	None	Mild	Moderate	Severe	
			Behaviors		
IX. Unsafe Behaviors	Never	Occasional	Regular	Continuous	
X. Dangerous to self or others	Never	Occasional	Regular	Continuous	
XI. Agitation (Describe behaviors in comments section)	Never	Occasional	Regular	Continuous	

10(f) Health care decision making capacity. Based on the preceding review of functional capabilities and physical and cognitive status and limitations, indicate this resident's highest level of ability to make health care decisions.

- ❑ (a) Probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences and burdens and risks of proposed treatment).
- ❑ (b) Probably can make limited decisions that require simple understanding.
- ❑ (c) Probably can express agreement with decisions proposed by someone else.
- ❑ (d) Cannot effectively participate in any kind of health care decision making.

11.* Ability to self-administer medications. Based on the preceding review of functional capabilities, physical and cognitive status, and limitation, rate this resident's ability to take his/her own medications safely and appropriately.

- ❑ (a) Independently without assistance
- ❑ (b) Can do so with physical assistance, reminders or supervision only
- ❑ (c) Need to have medications administered by someone else

_____ _____
Print Name Date

_____ _____
Signature of Health Care Practitioner License No. and Category

Resident Name_____
Date of Birth_____ Date Completed_____

PRESCRIBERS MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all):_____

_____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is *not* to be crushed please indicate.

12(a) Medication(s). Including PRN, OTC, herbal, and dietary supplements. **Include dosage, route (p.o., etc.), frequency, duration (if limited).**	**12(b) All related diagnoses, problems, conditions.** **Please include all diagnoses that are currently being treated by this medication.**	**12(c) Treatments (include frequency and any instructions about when to notify the physician).** **Please link diagnosis, condition or problems as noted in prior sections.**	**12(d) Related testing or monitoring.** **Include frequency and any instructions to notify physician.**

Prescriber's Signature_____ Date_____

Office Address_____ Phone #_____

_____ _____

Signature of RN who has reviewed and reported the above by family, resident, and pharmacy dispensed medication supplied at time of review. Date