

**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 _____

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