RIVER GARDEN SENIOR SERVICES | Hebrew Home Wolfson Health & Aging Center

LONG-TERM CARE PROGRAM
APPLICATION INFORMATION & PRE-ASSESSMENT

All questions refer to the applicant except where stated or directed.

Applicant Name:_____ Date of birth:_____ Age:_____

Current Address:_____

City:_____ County:_____ State:_____ Zip Code:_____

How long has applicant lived at this address? _____

Prior Address (if above address is less than 5 years): _____

City:_____ County:_____ State:_____ Zip Code:_____

CURRENT STATUS OF APPLICANT (before admission to River Garden)

Lives alone? Yes ☐ No ☐ If no, with whom? _____ For how long? _____

Who is primary caregiver(s) now? _____

Why is nursing home care needed at this time? _____

_____

_____

Why did you choose River Garden? _____

_____

Have you had any family or friends receive care at River Garden? Yes ☐ No ☐

If yes, who? _____

APPLICANT AND FAMILY HISTORY

APPLICANT'S EARLY LIFE

Place of Birth: _____ Are you a US citizen? _____

Father's Name: _____ Mother's Name: _____

Please list names, ages, and current location of living siblings: _____

_____

MARITAL STATUS

Current Status: Married ☐ Divorced ☐ Widowed ☐ Single ☐

Date of most recent marriage: _____ Name of Spouse: _____

How/when marriage ended: _____

Date of prior marriage: _____ Name of Spouse: _____

How/when marriage ended: _____

_____

CHILDREN

How many children does applicant have? _____

Are all children and family members in agreement with placement? _____

SPIRITUALITY

Religious ritual: Orthodox ☐ Conservative ☐ Reconstruction ☐ Reform ☐ Jewish ☐
No particular movement ☐
Other religious affiliation: ☐ (please list _____) None ☐

EDUCATION

What is the highest grade completed? _____ College degree? Yes ☐ No ☐

RETIREMENT FROM WORK

Prior occupation: _____ Date of Retirement: _____

Volunteer work subsequent to retirement: _____

DIETARY NEEDS

Are there special dietary needs? Yes ☐ No ☐ If yes, please describe _____

_____

Have you received the River Garden Policy on Nutrition and Hydration? Yes ☐ No ☐

Has the applicant discussed his or her feelings regarding alternate feeding methods, such as gastric tube feedings, if adequate nutrition and hydration by mouth cannot be achieved if death is not imminent?
Yes ☐ No ☐ If yes, what are the applicant's feelings about this? _____

_____

SPECIAL SKIN NEEDS

Are there any known skin problems or open areas on the skin at this time? Yes ☐ No ☐

If yes, where? _____

MENTAL HEALTH HISTORY

Is the applicant currently under the care of a psychiatrist or psychologist? Yes ☐ No ☐

If yes, name and address of psychiatrist/psychologist: _____

_____

_____ Date last seen: _____

Treated for what condition? _____

_____

Have there been any attempts or threats of suicide? Yes ☐ No ☐ How recently? _____

Has the applicant ever been involuntarily admitted to a mental health facility (i.e. Baker Acted or Myers Acted)? Yes ☐ No ☐ If yes, when and to what facility? _____

_____

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BEHAVIORS

Is there presently any purposeless walking or wandering? Yes ☐ No ☐ If yes, when does it usually occur? _____

Are there combative or aggressive behaviors? Physical? _____ Verbal? _____
What triggers combative or aggressive behaviors? _____

_____

If assistance is needed with daily care, has the assistance ever been resisted or fought off? Yes ☐ No ☐
Is the applicant fearful/anxious? _____

Is there evidence of overly suspicious behavior? Yes ☐ No ☐ If yes, describe behavior: _____

_____

Is the applicant comfortable in social settings? _____

Is the applicant bothered by excessive noise and/or activity? _____

Is disrobing common? _____

What is the applicant's current cognitive or mental status? _____

_____

Is the applicant compliant with medications/treatment? _____

_____

Is there any history of alcohol or drug dependency? _____
Has the applicant ever been charged with a felony offense? Yes ☐ No ☐ If yes, please explain: _____

_____

_____

FAMILY CONTACTS Please list Spouse and all children (use additional sheets, if necessary)

1. Name	Name of spouse
Address	Phone #'s: Home:
City	Cell:
State Zip Code:	Work:
Relationship to applicant	E-mail:
2. Name	Name of spouse
Address	Phone #'s: Home:
City	Cell:
State Zip Code:	Work:
Relationship to applicant	E-mail:
3. Name	Name of spouse
Address	Phone #'s: Home:
City	Cell:
State Zip Code:	Work:
Relationship to applicant	E-mail:

LONG TERM CARE PROGRAM APPLICATION INFORMATION AND PRE-ASSESSMENT

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4. Name	Name of spouse
Address	Phone #'s: Home:
City	Cell:
State Zip Code:	Work:
Relationship to applicant	E-mail:
5. Name	Name of spouse
Address	Phone #'s: Home:
City	Cell:
State Zip Code:	Work:
Relationship to applicant	E-mail:
6. Name	Name of spouse
Address	Phone #'s: Home:
City	Cell:
State Zip Code:	Work:
Relationship to applicant	E-mail:
7. Name	Name of spouse
Address	Phone #'s: Home:
City	Cell:
State Zip Code:	Work:
Relationship to applicant	E-mail:
8. Name	Name of spouse
Address	Phone #'s: Home:
City	Cell:
State Zip Code:	Work:
Relationship to applicant	E-mail:

ADVANCE DIRECTIVES

Please mark all advanced directives that have been executed for applicant and provide copies of documents for completion of the application.

☐ Legal guardian

☐ Durable power of attorney for financial

☐ Durable power of attorney for health

☐ Health Care Surrogate

☐ Living Will

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Is there anything else you would like to make us aware of?

I understand that any false or misleading statement or information given in the application or during the interview process that subsequently affects River Garden's ability to provide care, or prove to be a safety concern for other residents/staff, may result in a denied admission. If this is determined post admission to River Garden, it may result in discharge from the facility.

Signature applicant/responsible party

Date

This form completed by:

Name

Relationship

Admission Department

Date application received: _____ By Whom? _____

LONG TERM CARE PROGRAM
FAMILY/CAREGIVER QUESTIONNAIRE

As part of our continuing efforts to ensure that our care meets the needs of our residents and their family members we are asking you to please take a few minutes to complete this pre-admission questionnaire.

1. What times are most convenient for you to meet with the Staff?
☐ Anytime ☐ Morning ☐ Afternoon ☐Phone Only ☐ Unable

2. How often has your family member routinely seen a physician in the last year?
☐ Daily ☐ Weekly ☐ Monthly ☐Every Other Month ☐ Annually

3. How often do you expect a physician to see your family member at River Garden?
☐ Daily ☐ Weekly ☐ Monthly ☐Every Other Month ☐ Annually

4. Does your family member have a diagnosis of Dementia/Alzheimer's?
☐ Yes ☐ No ☐Unsure

5. **If yes, please indicate the level.** ☐ Mild ☐ Moderate ☐ Severe

6. If yes, has a physician formally educated you on the disease process? ☐ Yes ☐ No

7. Please check or list all other diagnosis related to your family member's condition.
☐ Parkinson ☐ Stroke ☐ Heart Condition ☐ Arthritis ☐ Fracture
☐ Renal Disease ☐ Respiratory ☐ None ☐ Other (please list)

_____

_____

8. Indicate any changes in your family member's weight during the last 90 days.
☐ Lost Weight ☐ No change ☐ Gained Weight

LONG TERM CARE PROGRAM
FAMILY/CAREGIVER QUESTIONNAIRE

9. How many times has your family member fallen in the last 90 days?
☐ 0 ☐ 1 ☐ 2 ☐ 3+

10. Please check the box that describes your feelings about the likelihood that your family member will fall in the first 90 days after he or she is admitted to River Garden.
☐ Very Likely ☐ Somewhat Likely ☐ Somewhat Unlikely ☐ Very Unlikely

11. How many days a week does he or she take a shower/bath? _____

12. How many days a week do you expect your family member to have a shower/bath at River Garden?
_____

13. How has your family member's general condition changed in the last 90 days?
☐ Improved Greatly ☐ Improved Slightly ☐ No Change ☐ Declined Slightly
☐ Declined Greatly ☐ Do Not Know

14. What are your expectations for your family member's general condition 90 days after admission to River Garden?
☐ Improved Greatly ☐ Improved Slightly ☐ No Change ☐ Declined Slightly
☐ Declined Greatly ☐ Do Not Know

APPLICANT NAME: _____

COMPLETED BY: _____ DATE: _____

Please be sure to complete the entire questionnaire and return it to our Admission Department.