BROAD REACH
LIBERTY COMMONS

Broad Reach Skilled Care Center at Liberty Commons
Admission Application & Resident Profile

Welcome! At Liberty Commons, we believe the more we know about a prospective resident, the better care we'll be able to provide. Each resident comes to us with a unique history and different needs. By taking some extra time to provide the information in this application, you will help our team develop an individualized plan of care to make the transition to long term care a smooth and positive one. Thank you for choosing Liberty Commons.

General Information

Date:_____ Anticipated Admission Date: _____

Applicant Name: _____

Home Address: _____

Phone: _____

Date of Birth: _____ Age: _____

Marital Status: _____ Sex: ☐Male ☐Female

Former Resident of a Nursing Home or other Adult Care Facility: ☐Yes ☐No

If yes, name of residence: _____

Services from a Home Health Agency: ☐Yes ☐No

If yes, agency name & services provided: _____

Primary Care Physician: _____ Phone: _____

Other Medical Providers: _____

Funeral Home: _____

Advance Directives *Please check applicable advance directives and attach copies of each document*

☐Health Care Proxy ☐Power of Attorney ☐Living Will ☐Conservatorship

☐Legal Guardian ☐Roger's Guardian ☐Do Not Resuscitate Order (DNR)/MOLST/5 Wishes

Is anticipated length of stay short term with return to community setting? ☐Yes ☐No

Has applicant participated in the decision for admission? ☐Yes ☐No

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Insurance Information *Please attach copies (front & back) of insurance cards*

Medicare #: _____

Part A (hospital insurance): ☐Yes ☐No

Part B (medical insurance): ☐Yes ☐No

Part D (pharmacy insurance): ☐Yes ☐No Company: _____

Social Security #: _____

Medicaid #: _____

Medicare Advantage Plan: _____

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Secondary/Long Term Care Insurance

Name of Company: _____ Policy Holder: _____

ID #: _____ Group #: _____ Phone #: _____

Other Insurance

Name of Company: _____ Policy Holder: _____

ID #: _____ Group #: _____ Phone #: _____

Medicaid Status: ☐Active ☐Pending ☐Not Applicable

If applying for Medicaid, caseworker name:_____ Date Application filed: _____

Attorney or Financial Advisor: _____

Medical Information & Care Needs

Current Diagnosis: _____

_____

Past Medical History: _____

_____

_____

Surgical History: _____

_____

Vaccination History: *Please indicate a date for each*

Pneumonia: _____ Flu: _____ Shingles: _____ Positive Mantoux: _____

Current Medications: *Please indicate dose & times of day*

_____

_____

Prosthesis: ☐Yes ☐No

If yes, please explain: _____

Allergies: *Drug, Food, Environment*

_____

_____

Mobility

☐Bed Bound ☐Wheelchair ☐Walker/Cane ☐Assist (#): _____ ☐Independent

What Durable Medical Equipment (DME) will you bring with you:

☐Walker ☐Wheelchair ☐Commode ☐Shower Chair ☐Specialty Cushion/mattress

☐Other: _____

Bathing Routine

☐Totally Dependent ☐Assist/Set ☐Independent

How often do you shower/bathe: _____

Do you shampoo at the same time or prefer a hairdresser appointment?: _____

Is applicant resistive to bathing?: ☐Yes ☐No

If yes, what techniques are successful?: _____

Dressing/Grooming

☐Totally Dependent ☐Assist/Set Up ☐Independent

Is there any special way you care for your hair/nails/shaving?: _____

Additional Comments: _____

Continence

☐Continent ☐Incontinent If yes, ☐Bowel ☐Bladder

Uses: ☐Toilet ☐Bedpan ☐Urinal ☐Bedside Commode ☐Depends/Briefs ☐Wakes at night

Has: ☐Ostomy ☐Catheter

Eating

☐Totally Dependent/tube feeding ☐Assist/Set Up ☐Independent ☐ Needs Encouragement

Mental Status

☐Alert Oriented to: ☐Person; ☐Place; ☐Time ☐Delusional ☐Lethargic ☐Hoards ☐Paranoid

☐Confused ☐Forgetful ☐Disoriented ☐Withdraws ☐Restless ☐ Depressive Symptoms

☐Visits with Others ☐Smiles/Laughs ☐Cries/Sad ☐Inappropriate ☐Apprehensive/Anxious

☐Hoards ☐Verbally Abusive to Others ☐Physically Abusive to Others ☐Hallucinates

Is this a change in mental status?: ☐Yes ☐No

If yes, please explain: _____

What triggers the negative behavior?: _____

What interventions work?: _____

What interventions do not work?: _____

Additional Comments: _____

_____

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Safety

Does the applicant have a history of falls?: ☐Yes ☐No

If yes, please explain the circumstances and frequency: _____

_____

Are any special safety measures in place for the applicant at his/her current place of residence?: _____

_____

Communication

Communication of needs: ☐Verbal ☐Body Language/Facial Expressions ☐Non-Communicative

☐ Language Barriers ☐Understands English ☐Can Make Needs Known in English or by Gestures

What is applicants primary language?:

If a communication barrier is present, is the applicant able to make needs known/How does the applicant compensate for the barrier?: _____

Vision

Visual Appliances: Glasses ☐Yes ☐No Contact Lenses ☐Yes ☐No Magnifying Glass ☐Yes ☐No

Please describe any visual limitations or difficulties such as decreased peripheral vision, leaves food on one side of plate, misjudges placement of chair when seating self-etc.: _____

_____

Hearing

Hearing Aid(s): ☐Yes ☐No ☐Right ☐Left If hearing aid is present, is it used? ☐Yes ☐No

Please describe any hearing limitations or difficulties and how we may improve communication: _____

_____

Resident Profile

What do you like to be called?:_____

Town/state you grew up in: _____

School/College: _____

Highest level of education: _____

Subject(s) of study:_____

Occupation: _____

Marital History: _____

Name(s) of Children: _____

Grandchildren: _____

Great Grandchildren: _____

Did you have pets?: _____

Military History:_____

Civic Organizations: _____

Notable Achievements/Awards/Honors: _____

Religious Preference: _____

Place of Worship: _____

Spiritual Activities of Comfort: _____

Services you hope for at Liberty Commons: _____

Favorite way to spend your time: _____

Hobbies & Leisure Activities: _____

Favorite Topics of Discussion: _____

Favorite Music: _____

What are your wishes for recreation programs?: _____

Time you like to rise in the morning: _____

Do you like to approve the clothes you wear each day?: ☐Yes ☐No

What do you like to do for yourself? ie. Brush teeth, wash face, everything but socks & shoes: _____

_____

What would you prefer others do for/with you?: _____

Time you like to go to bed: _____

What you like to wear to bed: _____

Do you need to get up to use the bathroom at night?: ☐Yes ☐No

Do you have difficulty sleeping?: ☐Yes ☐No

If yes, what helps: _____

What time do you like to eat: Breakfast _____ Lunch _____ Dinner _____

Favorite Foods: _____

Foods You Dislike: _____

Dietary Restrictions: _____

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Please tell us anything we can do to make you feel more at home or tell us about anything important to you that we haven't asked yet. _____

_____

_____

This information can be used to create a short biography so that from the first days of admission, our new residents will be known as the unique individuals they are. Some of the social information may be displayed outside the resident's door. You will be shown the information prior to display and will have the opportunity to add information if desired.

☐ **Please mark here if you do NOT want the biography displayed.**

Contact Information

Billing Address:

Name: _____ Relationship: _____

Address: _____

Home phone: _____ Business phone: _____

Cell Phone: _____ Email Address: _____

Primary/Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Home phone: _____ Business phone: _____

Cell Phone: _____ Email Address: _____

Alternate Contact:

Name: _____ Relationship: _____

Address: _____

Home phone: _____ Business phone: _____

Cell Phone: _____ Email Address: _____

Other Contact:

Name: _____ Relationship: _____

Address: _____

Home phone: _____ Business phone: _____

Cell Phone: _____ Email Address: _____

Attorney:

Name: _____ Business phone: _____

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This application was completed by: _____

Relationship to Applicant: _____ Phone number: _____

Application Checklist:

☐All Health Insurance Cards ☐All Court Appointed Documentation (Guardianship/Conservatorship)

☐Long Term Care Insurance (if applicable) ☐ Advance Directives: Health Care Proxy, Durable Power of Attorney, Living Will, Comfort Care Forms