ST. FRANCIS
ASSISTED LIVING FACILITY

65 W. CLOPTON STREET
RICHMOND, VIRGINIA 23225
PHONE# (804)231-1043
FAX# (804)231-1065

APPLICATION FOR ADMISSION

Name of Applicant ________________________________ Social Security Number ___________________
Applicants Present Address ____ Zip________________
Age _______ Birthdate __________ Birthplace ____
Martial Status __________________________ Phone# ____
Spouse's Name__________________________ Spouse's Social Security Number _____________________
Spouse's: Age ________ Birthdate ____________ Birthplace ___________________________________
Present Living Arrangements ____

CORRESPONDENCE INFORMATION

Person Supplying Information ______________________________ Relationship ____________________
Person To Whom Correspondence Should Be Sent ____
Address ____ Phone Number ______________________
E-mail Address ____

LEGAL REPRESENTATIVE INFORMATION , IF APPLICABLE (Please provide current legal documents that show proof of each legal representative's authority to act on behalf of the resident. The documents must also specify the scope of the representative's authority to make decisions and to perform other functions).

Name: ____
Address: ____
Phone: ____

HEALTH INSURANCE INFORMATION (Please provide copies of all health insurance cards)

Medicare Number ____
Part A (Effective Date ____________________ Part B (Effective Date) ______________________
Medicaid Number _________________________________ Eligibility Date ______________________
Other Health Insurance ____________________________ Policy Number ______________________
Address ____ Phone Number ______________________
Long Term Care Insurance _________________________ Effective Date ______________________
Address ____ Phone Number ______________________
Prescription Medication Insurance Plan _________________________ Effective Date ______________
Address ____ Phone Number ______________________
Military Prescription Benefits? Yes ______ No _______

EDUCATIONAL/EMPLOYMENT HISTORY

Educational Level ____________________ Spouse's Educational Level ____________________

Lifetime Vocation, Career, or Primary Role: ____________________

____

Retirement Date(s) ____________________ Reason(s) for Retirement ____________________

Service in the Armed Services? Yes ______ No______

Branch of Armed Services ____________________

	NAME	PHONE
ATTENDING PHYSCIAN		
DENTIST		
HOUSE OF WORSHIP/CLERGY		
SOCIAL SERVICE/ CASEWORKER		

PHYSICAL CONDITION OF APPLICANT

Has Applicant ever been in a hospital? Yes ______ No ______

Last Admission Date ____________ Last Discharge Date ____________ Name of Hospital ____________

Reason for Most Recent Admission ____________________

Has Applicant ever been in a nursing home? Yes ______ No ______ Latest Admission Date ________

Latest Discharge Date ____________________ Name of Home ____________________

Reason for Admission ____________________

Has applicant ever been in another assisted living or retirement community? Yes ______ No ______

Name of assisted living community (is): ____________________

____

Reason for leaving ____________________

Please check all limitations that are applicable:

__ Eyesight __ Hearing __ Uses Crutch, Cane, Walker

__ Epilepsy __ Cancer __ Tuberculosis

__ Wheelchair __ Diabetes __ Heart Trouble __ High Blood Pressure

Any Contagious Disease ____________________ Paralyzed ____________________

Physical Deformity ____________________

Does the Applicant handle his/her own finances? Yes ______ No ______

Can the Applicant use the bathroom without assistance? Yes ______ No ______

Can the Applicant bathe without assistance? Yes ______ No ______

Can the Applicant dress himself/herself? Yes ______ No ______

Can the Applicant do light housekeeping chores such as dusting? Yes ______ No ______

List all prescription and non-prescription medications take by the Applicant ____________________

____

____

____

____

____

____

Who presently administers the medication? ____________________

PERSONAL/SOCIAL DATA

Description of Family Structure and Relationships:
Hobbies and Interests:
Previous Mental Health/Mental Retardation Services History:
Current Behavioral and Social Functioning Including Strengths and Problems:
Substance Abuse History:

EMERGENCY INFORMATION

In case of serious illness, emergency, or death, whom should the facility staff notify?

Name ______________________ Telephone ______________________

Address ______________________

Names and Addresses of Living Children or Nearest Relatives:

Name ______________________

Address ______________________

Telephone ______________________

Relationship ______________________

E-mail ______________________

Name ______________________

Address ______________________

Telephone ______________________

Relationship ______________________

E-mail ______________________

Name ______________________

Address ______________________

Telephone ______________________

Relationship ______________________

E-mail ______________________

Name ______________________

Address ______________________

Telephone ______________________

Relationship ______________________

E-mail ______________________

ASSETS

1. Sources Of Income (monthly)

	Total
Social Security	
Pension*	
Annuity*	
Trust account income	
Income from stocks and bonds	
Interest income from savings and CDs	
Other income sources	
TOTAL	

*If amount of any pension or annuity is expected to increase or decrease in future years (cost of living adjusted) or will be discontinued or decreased in event of death of spouse, please explain: ______________________________

____

2. Cash: Checking account total (combine all checking accounts) Amount: ______________

3. Savings accounts and/or Certificates of Deposit

Institution	In Name of	Type of Account	Amount

TOTAL: ______________

4. Individual Retirement Account (IRA)

Institution	In Name of	Beneficiary	Amount

TOTAL: ______________

5. Stocks, bonds, and marketable securities (attach additional page if needed)

Description	In name of	No. of shares	Current Market Value	Amount

TOTAL: ______________

6. Monthly Expenses

Description	Amount

TOTAL: ______________

7. Accounts and Bills due: Insurance Premium ______________________________

____

____

8. Other Liabilities (credit cards, etc.) ______________________________

If someone other than the applicant prepares this statement, please complete the following:

Name of Preparer ______________________ Telephone ______________

Address ______________________________

Certification:

I/We certify that all information in this Financial Statement is accurate to the best of my/our knowledge and belief. I/We agree to notify St. Francis Home immediately of any significant changes in my/our financial condition should occur. I/We are aware that any material misrepresentation or omission shall authorize involuntary termination of my/our contract by St. Francis Home (See Section V--D--4 of Agreement Document 100) and that disposing of assets can cause termination of contract for services.

______________________________	______________________________
Signature	Date

ADDENDUM TO FINANCIAL STATEMENT

POWER OF ATTORNEY; DURABLE MEDICAL POWER OF ATTORNEY; GUARANTOR
REQUIREMENTS FOR APPLICANTS TO AND RESIDENTS OF
SAINT FRANCIS HOME

1 A RESIDENT WITH A PRIMARY OR SECONDARY DIAGNOSIS OF "DEMENTIA" WILL BE REQUIRED TO HAVE A LEGALLY APPOINTED POWER OF ATTORNEY AND DURABLE MEDICAL POWER OF ATTORNEY PRIOR TO ADMISSION TO SAINT FRANCIS HOME, AND AT ANY TIME FOLLOWING ADMISSION THAT SUCH DIAGNOSIS MAY BE MADE.

2 A RESIDENT WITH AN ASSESMENT OF BEING INCAPABLE OF MANAGING HIS/HER FINANCES MAY BE REQUIRED TO HAVE A GUARANTOR NAMED TO ASSUME RESPONSIBILITY FOR PAYMENT OF ANY AND ALL DEBTS INCURRED BY THE RESIDENT.

______________________________	______________________________
RESIDENT	DATE
______________________________	______________________________
POWER OF ATTORNEY FOR RESIDENT	DATE

SAINT FRANCIS HOME

Resident-Personal/Social Data

Name Social Security Number Marital Status

Last Home Address Address from which Received

Date of Admission Date of Birth Birth Place

Interests/Hobbies
Vocation/Career

Branch of Service

Advance Directive
Living Will
DNR

Personal Representative Name__________ Address__________ __________ Telephone(s)__________	Personal Physician Name__________ Address__________ __________ Telephone(s)__________
Personal Dentist Name__________ Address__________ __________ Telephone(s)__________	Clergyman/Place of Worship, If Applicable Name__________ Address__________ __________ Telephone(s)__________
Next Of Kin Name__________ Relationship__________ Address__________ __________ Telephone(s)__________	Next of Kin Name__________ Relationship__________ Address__________ __________ Telephone(s)__________
Local Department of Social Services, If Applicable Agency Name__________ Caseworker__________ Telephone(s)__________ Fax #__________	Other Agency, If Applicable Agency Name__________ Caseworker__________ Telephone(s)__________ Fax #__________

COPY OF LEGAL DOCUMENTS/PROOF OF LEGAL REPRESENTATIVE

ASSISTED LIVING RESIDENTS – ADDITIONAL SOCIAL DATA

1. DESCRIPTION OF FAMILY STRUCTURE AND RELATIONSHIPS

____

____

____

____

2. PREVIOUS MENTAL HEALTH/MENTAL RETARDATION SERVICES HISTORY IF APPLICABLE FOR CARE OR SERVICES

____

____

____

____

3. CURRENT BEHAVIORAL AND SOCIAL FUNCTIONING INCLUDING STRENGTHS AND PROBLEMS

____

____

____

____

4. SUBSTANCE ABUSE HISTORY IF APPLICABLE FOR CARE OR SERVICES

____

____

____

____

SAINT FRANCIS HOME

Self Assessment

To be completed by Applicant or his/her personal representative

Saint Francis Home offers Residential and Regular Assisted Living care. To help ensure your quality of care should you become a resident of our Home, we ask that you assess your health and care needs.

The confidentiality of the information provided will be respected. Thank you.

______________________ ______________________
Name of Applicant *Date*

______________________ ______________________
Person Completing Form *Relationship to Applicant*

Do you need Assistance with any of the following Activities of Daily Living {check (x)}

	No Assistance	Some Assistance	Total Assistance
BATHING			
DRESSING			
TOILETING			
EATING/FEEDING			
WALKING			
WHEELING			
TRANSFERRING			
MEDICATION MGT.			
INCONTINENCE:	NEVER	OCCASIONALLY	USUALLY
BOWEL			
BLADDER			

Record all diseases and injuries, as determined by a physician, that currently affect you.

____
____
____
____
____

List all medications that you currently take:

______ ______ ______
______ ______ ______

Do you have impaired VISION, HEARING, SPEECH?
If so, specify:

____
____
____

Do you require a special diet, as prescribed by a physician?______________
If so, specify:

____
____

Do you require on-going medical &/or nursing needs?________________

____
____

Please check all special treatments currently needed.

_____ Bowel/Bladder Training
_____ Dialysis
_____ Dressing/Wound Care
_____ Eye drops or Ointment
_____ Glucose/Blood Sugar Testing
_____ Injections/IV Therapy
_____ Oxygen
_____ Radiation/Chemotherapy
_____ Ventilator Care
_____ Other:

____
____

Do you have any mental or emotional impairments?
If so, please specify:

____
____

Over the last 90 days, has the individual displayed any exit seeking behaviors?

____
____

REPORT OF RESIDENT PHYSICAL EXAMINATION

(Examination is to be completed by an independent physician within 30 days prior to the date of admission. Report is to be kept as part of the person's permanent record.)

NAME DATE OF PHYSICAL EXAMINATION:

ADDRESS

TELEPHONE

Height: ____________ Weight: ____________ BP: ____________

Significant Medical History:

General physical condition, including systems review as is medically indicated:

Allergies (food, medicine, or other):

Is this person:

___ Ambulatory (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building Code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such resident may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate).

___ Nonambulatory (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person).

Does this individual have any of the following conditions or care needs? Name ______________________

Condition/Care Need	Yes	No	Comment
Ventilator dependency			
Dermal ulcers III and IV			If stage III is ulcer healing?
Intravenous therapy or injections directly into the vein			If intermittent therapy please note and indicate expected time period.
Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission			
Psychotropic medications without appropriate diagnosis and treatment plans			
Nasogastric tubes			
Gastric tubes			If yes, is person capable of independently feeding himself and caring for the tube?
Presents imminent physical threat or danger to self or others			
Requires continuous licensed nursing care			

Name ____________________

Diagnosis or significant problems:

____

____

____

____

____

____

Recommendations for care:

Medications:

____

____

____

____

____

Diet: ____

____

____

____

Therapy: ____

____

____

____

Signature: ______________________________________ Date: ____________________

____
(Please print or type physician's name here)

Address (Street, City, State, Zip Code)

______________________________________ Telephone: ____________________

REPORT OF TB SCREENING

Name: ______________________________ Date of Birth: __________

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by ______________________________.
(Name of health dept/facility/practice)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ A tuberculin skin test (PPD) was administered on __________ and results, read on ________, were as follows:

_______ mm _____ Negative _____ Positive.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray on __________ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature/Title: ______________________________ Date: __________
(MD/designee or Health Department Official)
Print Name/Title: ______________________________ Phone: __________
Address: ______________________________
____
____

REPORT OF TUBERCULOSIS SCREENING EVALUATION

Name ______________________________ **Birthdate** ____/____/____

Address ______________________________

____

1. **Date and result of most recent Mantoux tuberculin skin test: Date: ____/_____/_____**
   mm of induration ______________

2. **Check here if previously positive and above information unknown ______________**

3. **Check here if exhibiting TB-like symptoms ______________**

4. **If TB skin test is 10 mm or greater (5mm in the HIV infected), previously positive or if TB-like symptoms exist, *respond to the following:***

   a. **Date of last chest x-ray evaluation: Date: ____/____/____**

   b. **Is chest x-ray suggestive of active TB? *(circle one)*** **YES** **NO**

   c. **Were sputum smears collected and analyzed for the presence of Acid Fast Bacilli (AFB)? *(circle one)*** **YES** **NO**

   d. **If 4c is YES, were three consecutive smears negative for AFB? *(circle one)*** **YES** **NO**

5. **Based on the above information, is this individual free of communicable TB? *(circle one)*** **YES** **NO**

6. **Name of licensed physician, physician's designee or local health department official completing the evaluation:**

______________________________ ______________________________
Print Name ***Phone***

7. **Signature of license physician, physician's designee or local health department official completing evaluation:**

______________________________ ________/________/________
Date

032-05-419 (8/99)

TO: PHYSICIANS ATTENDING RESIDENTS OF SAINT FRANCIS HOME
RE: STANDARDS AND REGULATIONS FOR LICENSED ASSISTED LIVING FACILITIES

Medications (prescription, over-the-counter and dietary supplements):
22 VAC 40-71-400 C.
Physician orders, both written and oral, for administration of all prescription and over-the-counter medications and dietary supplements shall include the name of the resident, the date of the order, the name of the drug, route, dosage, strength, how often medication is to be given, **and identify the diagnosis, condition, or specific indications for administering each drug.**

As of 12/28/05 each medication prescribed for residents of Virginia licensed assisted living facilities must include the diagnosis, condition, or specific indications for administering each drug.

Please use the following form to provide this information for each medication you have prescribed for:

____
PATIENT (Saint Francis Home Resident)

MEDICATION	DIAGNOSIS CONDITION INDICATIONS FOR TAKING DRUG	SIGNIFICANT ADVERSE EFFECTS	DATE Prescribed	ADDITIONAL INFORMATION OR SPECIAL INSTRUCTIONS
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Please attach written orders for each medication, and return to
Saint Francis Home | 65 W. Clopton Street | Richmond, VA 23225
Tel: 804 231-1043 Fax: 804 231-1065

Physician's Signature ______________________________ Date:__________