RESIDENTIAL CARE HOME

Initial Enrollment Packet

WELCOME

Greetings and welcome to Our Father's House! We appreciate your interest in our agency. We hope we will be able to meet your needs. Please read through this packet carefully and complete it to the best of your ability. Feel free to call us if you have any questions or concerns. We are here to serve you.

This packet contains primary information we need in order to consider enrollment/ placement. Additional forms must be completed prior to final enrollment. Please submit the Initial Enrollment Packet. You will be contacted within 1-14 days for an in-depth assessment and interview. Thank you for considering Our Father's House for your care needs.

Enrollment Policy

The staff of Our Father's House is committed to providing you or your loved one with a positive, loving, and comforting experience. We are committed to ensuring your safety and well-being at all times.

Enrollment criteria are as follows:

Day Center	Residential Care	
√	√	Applicants must be at least 50 years of age.
√	√	Applicants must be free of communicable diseases.
√		Applicants may have symptoms of memory loss or dementia verified by applicant's physician.
√	√	Applicants must be medically stable. Families/client must provide any special medical supplies and/or equipment needed to ensure compliance with the health care needs of the applicant.
√	√	Applicants must be mobile or ambulate with a cane, walker, or wheelchair. Applicants with poor balance or an unsteady gait must use a cane, walker or wheelchair to avoid falls or injury.
√	√	Applicants must be able to use the restroom/toilet with minimal assistance. Individuals in wheelchairs must be able to assist in their own transfer and/or bear their own weight while being transferred.
√	√	Applicants must be able to feed themselves with minimal assistance.
√	√	Incontinent individuals may be enrolled. Incontinent aids/supplies must be provided by the client/family.
√	√	Applicants' families must agree to comply with all polices of the Center/Care Home.

Your signature below indicates you have reviewed the Enrollment Policy along with staff and that I agree to comply with conditions.

_______________________________ _______________________
Client Signature Date

_______________________________ _______________________
Caregiver Signature Date

_______________________________ _______________________
Staff Representative Date

Client's Name: ____

<table>
<tr><th colspan="3"><u>ADMISSION DATA</u></th></tr>
<tr><td colspan="2">Date:</td><td>Interview /Enrollment Date:</td></tr>
<tr><td>Date of Birth:</td><td>Medicare:</td><td>Phone:</td></tr>
<tr><td colspan="3">Current Address:</td></tr>
<tr><td colspan="2">City, State, Zip</td><td></td></tr>
<tr><td>Gender (Please circle) M F</td><td colspan="2">Email:____ _______________</td></tr>
<tr><td colspan="3">Which Service Are You Applying For? ____Day/Memory Center: Days Attending: M T W TH F
_____Short-term Respite: (How many days?)____ ____Residential Care Home</td></tr>
<tr><td colspan="3">Racial/Ethnic Background: White Black Hispanic Asian Other: _______</td></tr>
<tr><td colspan="3">Marital Status: Single Married Widowed Divorced Separated</td></tr>
<tr><td colspan="3">Contact Person/Caregiver: ____</td></tr>
<tr><td colspan="3">Relationship to Member: ____</td></tr>
<tr><td colspan="3">Current Home Environment Live Alone? Yes_____ No_____ Number in Household: _______
Live With: _______________________________________ Relationship: ___________________</td></tr>
<tr><td colspan="3">How does your loved one feel about enrollment/placement?
___Accepting ___Complacent ___Angry ___Doesn't Comprehend
___Depressed ___Unaware ___Bitter ___N/A (self enrollment)</td></tr>
</table>

ADMISSION DATA

Mode of Transportation to/from the Center: ____N/A
____Private Auto _____Metro ____Car Pool
____Connect Transportation _____Center Van ____Other

SIGNATURES

Printed Name of Applicant:______________________________________ __________________	Date: ________________
Signature of Applicant:______________________________________ __________________	Date: ________________
Person completing this form:____	Date: ________________
Printed Name:____ ___________	Your Position:________________ __
Agency Name:____ __________	Agency Phone:_________________

PERSONAL DATA

Birthplace:	# of Siblings:	# Still Living:	
Spouse's Name:		Is spouse living ___Yes ___No	
Children?	# Still Living	Grandchildren:	Great-grandchildren

Where was childhood spent: ____Farm ____Ranch ____Small Town ____City ____Metro ____Unknown _____Other/Specify _____________________ Primary Language: ________
Comments:
____

PERSONAL DATA

HEALTH

Primary Diagnosis:______________________________________ Date of Diagnosis:_______

Secondary Diagnosis: _____________________Condition under control? ___Yes ___No

If dementia diagnosis, any behavior challenges? ___Yes ___No Please specify:

___Combativeness ___Wandering ___Aggressive ___Incontinence ___Agitation

___Other, please specify?

____

What do you do to deter the challenging behavior?

____

____

____

What triggers this challenging behavior?

____

What activity does your loved enjoy most?

____

Medications: ____-

____

EDUCATION/ MILITARY SERVICE

____No formal Education ____Some High School ____Trade School ____College

____8th grade or less ____H.S. Graduate ____Some College

____Graduate Studies

_____Army _____Air Force ____Coast Guard ______Navy _____Marines ____ Reserves

OCCUPATION

___Self Employed ___Clerical ___Manager ____Labor ____Financial ____Real Estate

___Public Service ___Medical ___Sales ____Teaching ____Laborer

____Food Service

___Domestic Services ___Homemaker ___Agriculture ___Engineering

____Unknown

___ Other/Specify: ________________________ Last Employer:

____

RELIGIOUS PREFERENCE

PERSONAL DATA

____Presbyterian ____Lutheran ____Methodist ____Baptist ____Other Christian
____Church of Christ ____Episcopal ____Catholic ____Jewish ____Atheist
____None ____Unknown ____Mormon _____Muslim____Other/ Specify______________

PERSONAL HABITS

Tobacco ___Yes ___No ____Cigarettes ____Cigars ____Chew ____Pipe ___Snuff
Alcohol ___Yes ___No ____Beer ____Wine ____Drugs (must be recovered)
Caffeine ___Yes ___No ____Coffee ___Tea ___Cola ____Chocolate

You can return this form via fax (713-429-5078), email (our.fathers.house.tx@gmail.com), or regular mail (OFH, Box 450068, Houston, TX 77245).

MEDICAL HISTORY (CONTINUED)

SENSORY - PERCEPTION

	Score	Comments	Scores
A. Vision			1. No impairment 2. Impairment compensated by aide device. 3. Impairment apparently associated with dementia, but not improved by use of an aide or device. 4. Impairment significant but does not use device. 5. Total loss.
B. Hearing			
C. Smell			
D. Touch			
E. Taste			

FUNCTIONAL ASSESSMENT

F. Physical Disability Score	G. Toileting-Bowel & Bladder Score

MEDICAL HISTORY (CONTINUED)

1. Ambulatory 2. Ambulatory with device (cane/walker) 3. Wheelchair, independent transfer skill. 4. Ambulatory with device and moderate assistance. 5. Wheelchair, dependent transfer skills.	1. Independent/Continent 2. Continent, reminder cues and minimum assistance. 3. Continent, reminder cues and moderate assistance, and has weekly accidents at most. 4. Incontinent more than once a day and may wear protective pad. 5. Incontinent, requires protective pad.
H. Feeding Score	*I. Bathing, Dressing & Grooming Score:*
1. Feeds self without assistance 2. Feeds self with minor preparation assistance. 3. Feeds self with frequent reminders. 4. Able to eat finger foods, but requires minor assistance. 5. Unable to feed self; requires full assistance.	1. Independent, Attends to all needs satisfactorily. 2. Independent, but requires selection and preparation cueing 3. Needs minor assistance in process. 4. Needs moderate assistance in process. 5. Unable to perform any of the task; requires full assistance.
COMMUNICATION ASSESSMENT	
J. Expressive Score:	K. Receptive Score:
1. No speech impairment, meaningful communicator 2. Mild speech impairment; occasional use of cues 3. Moderate speech impairment; frequent use of cues, limited vocabulary and occasional preservation 4. Advanced loss of speech power 5. Complete loss of speech.	1. No impairment; follows directions 2. Impaired comprehension: simple one-step direction; (mimics and has slowed response time) 3. Advanced Impairment; (a) Unable to use familiar objects properly or perform purposeful movements, and or (b) loss of power to recognize sensory stimuli. 4. Advance loss of verbal understanding or written word. 5. Complete loss of receptiveness.
General: ____ ____ ___	Sum A-K for SADC Physical Assessment Score (11-55). Lower score indicates greater number of areas of independence. **Overall Score:**

MEDICAL HISTORY (CONTINUED)

PRIMARY CARE PHYSICIAN:	PHONE:

MEDICAL HISTORY (CONTINUED)	
Address:	City, State, Zip Code:
Specialty:	Hospital:
OTHER PHYSICIAN:	Phone:
Address:	City, State, Zip Code:
Specialty:	Hospital:
OTHER PHYSICIAN:	Phone:
Address:	City, State, Zip Code:
Specialty:	Hospital:

HOSPITALLIZATION: Hospital of Choice:
Most recent Admission:
Reason for Admission:
____
____
____

Please tell us about any EMOTIONAL or PHYSICAL TRAUMAS, MAJOR SURGERY and ILLNESS

____
____
____
____
____
____
____
____
____
____
____
____

Client’s Name: ____

Screening Exam & Health Assessment

Orientation: { } Person { } Place { } Time { } Day { } Date { } Season

Height ______ Weight _____ Temperature_____ Pulse_____ Respiration_____ BP_____

General Appearance (grooming and hygiene): ______________________________________
____

Vision: Wears glasses for:
{ } Distance { } Reading { } Refuses to Wear { } History of Losing Glasses
Hearing: { } WNL { } HOH { } Left { } Right { }Hearing Aid
{ } Refuses to Wear Hearing Aid
Oral: { } Own Teeth { } Dentures { } Full { } Partial { } Upper
{ } Lower { }Refuses to Wear Condition of teeth or dentures:
____

Skin: { } Open area, lesions { } WNL (warm, pink, dry} Other: _________________________

Continent: Bowel { } Yes { } No Bladder { } Yes { } No Frequency { } Yes { } No
Incontinent Supplies: ______________________ { }Assistance { } Reminder

Ambulation: { } Independent Assertive Device: { } Wheelchair { } Walker { } Cane
Distance: { } Short { } Medium { } Long Posture: { } Good { } Fair { } Unfair
Balance: { } Good { } Poor Gait Patter: { }Steady { } Unsteady

Range of Motion: { } WNL { } Limited ____

Shortness of Breath with Activity: { } Yes { } No **Wanders/Paces** { } Yes { } No

Eating: { } Difficulty swallowing { } Difficulty chewing { } Independent { } Assist Appetite___

History of Communicable Disease { }Yes { }No **History of Psych Disease** { }Yes { }No

Chronic Physical complaints: { } Yes { } No Describe: ______________________________

Sleeps Well at Night: { } Yes { } No **Naps during the day:** { } Yes { } No

Speech: { } WNL { } Word Salad { } Diminished Verbalization Spoken Language: __________

Comprehension: { } WNL { } Requires Non-Verbal Cues i.e. _________________________

Reads: { } Yes { } No **Comprehends:** { } Yes { } No

Attention/Retention: { } Less than 5 minutes { } More than 5 minutes

Judgment Impairment: { } Mild { } Moderate { } Severe

Hallucination: { } Auditory { } Visual Cooperative: { } Yes { } No

Problem Behavior: { } Combative { } Verbally Abusive { } None { } Other _______________

Person completing this form:____
RN review:____ Date:_____________________

Medication Administration

Client name:____________________________________ Diagnosis:___________________________

Current Medications

RN Review:____ Date:__________________________

	NAME	Purpose	Doctor	Pharmacy	Dosage	Frequency