

Today's Date: _____

HIGH ISLAND CREEK RESIDENCE
A MINISTRY OF THE LUTHERAN
HOME ASSOCIATION



HOPE RESIDENCE
A MINISTRY OF THE LUTHERAN
HOME ASSOCIATION



Application for Admission

Please type or print in ink and fill out all items. If not applicable or available, please indicate. Please attach current photo of applicant to application.

General

Applicant's Name: _____
Last First Middle

Present Living Arrangement: _____

Address: _____

Date of Birth: _____ Male _____ Female _____

Place of Birth: _____
City County State

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Race: _____

Social Security Number: _____

Marital Status: _____ Citizenship Status: _____

Language Spoken or Understood: _____

Has a legal guardian been appointed by the court: Yes _____ No _____

If so when and where: _____

Name of Guardian: _____ Relationship: _____

Address: _____

Phone Number: _____ Email: _____

Case Manager: _____ County: _____

Phone Number: _____ Email: _____

Financial Worker: _____ County: _____

Phone Number: _____ Email: _____

Reason for Referral: _____

Family

In Case of Emergency Notify: _____

Relationship to Applicant: _____

Address: _____

Phone Number: _____ Work Phone Number: _____

Father's Name: _____ Phone Number: _____

Address: _____

Mother's Name: _____ Phone Number: _____

Address: _____

Siblings: Include names, addresses, telephone numbers and their relationship to applicant

Residential

(Parental, Board and Care, Foster Home, Group Home, Nursing Home, State Hospitals, etc.)

<u>History (List)</u>	<u>Date Stated</u>	<u>Date Terminated</u>	<u>Reason Terminated</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Contact Person: _____

Phone Number: _____ Email: _____

Address: _____

Educational/Vocational

(School, DT & H, Employment, etc.)

<u>History (List)</u>	<u>Date Stated</u>	<u>Date Terminated</u>	<u>Reason Terminated</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Contact Person: _____ Position: _____

Address: _____

Phone Number: _____ Email: _____

The applicant is interested in work outside of the facility: Yes _____ No _____

Social

List any current psychological or psychiatric services that are presently being used

<u>Name</u>	<u>How Long</u>	<u>Reason</u>
Psychological _____	_____	_____
Psychiatric _____	_____	_____

Describe applicant’s daily routine:

Check items which describe applicant’s current level of functioning

- | | |
|--|---|
| <input type="checkbox"/> Walks independently | <input type="checkbox"/> Verbal |
| <input type="checkbox"/> Walks with staff assistance | <input type="checkbox"/> Non-Verbal |
| <input type="checkbox"/> Uses walker/cane | <input type="checkbox"/> Understands speech of others |
| <input type="checkbox"/> Uses a wheelchair | <input type="checkbox"/> Communicates by gestures |
| <input type="checkbox"/> Climbs steps | <input type="checkbox"/> Other method of communication |
| <input type="checkbox"/> Eats independently | <input type="checkbox"/> Grooming, hygiene, bathing independently |
| <input type="checkbox"/> Needs assistance to eat | <input type="checkbox"/> Needs assistance with grooming, hygiene, bathing |
| <input type="checkbox"/> Regular Diet | <input type="checkbox"/> Needs help in toileting |
| <input type="checkbox"/> Uses disposable products | <input type="checkbox"/> Modified diet, describe: _____ |
| <input type="checkbox"/> Toilets independently | |

Check items which apply to applicant's social behavior

<input type="checkbox"/> Accepts help	<input type="checkbox"/> History, if any of sexual activity	<input type="checkbox"/> Enjoys being with others
<input type="checkbox"/> Follows simple directions	<input type="checkbox"/> Sexuality training	<input type="checkbox"/> Prefers to be alone
<input type="checkbox"/> Does not accept help	<input type="checkbox"/> Moods change frequently	
<input type="checkbox"/> Has temper outbursts	<input type="checkbox"/> Is calm, stable, rarely disturbed	<input type="checkbox"/> Unpredictable behavior

Check those items which describe applicant's current challenges or behaviors:

<input type="checkbox"/> Verbal aggression	<input type="checkbox"/> Physical aggression	<input type="checkbox"/> Property destruction
<input type="checkbox"/> Elopement	<input type="checkbox"/> Self-injurious behaviors	<input type="checkbox"/> Sexual inappropriateness
<input type="checkbox"/> Socially offensive	<input type="checkbox"/> Other _____	

Please describe:

Spiritual

Note: We do not discriminate on the basis of race, creed or national origin. We are concerned with the spiritual needs of the clients. These questions are asked with this intent.

Church Affiliation- Name of Congregation: _____

City and State: _____ Phone Number: _____

Financial

Checking Account: Yes _____ No _____ If yes, amount: _____

Savings Account: Yes _____ No _____ If yes, amount: _____

Account Name and Address: _____

Trust (supplemental or special needs): Yes _____ No _____ Where: _____

Source of Income: (Please list type, i.e. MA, SSI, MSA, RSDI, etc. and amount)

Representative Payee: Yes _____ No _____ Name: _____

Phone Number: _____ Email: _____

Address: _____

Funeral Arrangements

Burial Account: Yes _____ No _____ If yes, Amount: _____

Designated Funeral Home: _____ Phone Number: _____

Address: _____

Burial Lot: Yes _____ No _____ If yes, Location: _____

**** The Medical History Application must accompany this application for applicant to be considered for admission by
The Lutheran Home – Hope Residence Admission Committee. ****

Medical History for Admission Application

Diagnosis

Primary: _____

Secondary: _____

Other: _____

Medical Assistance #: _____ Medicare Number: _____

Other Insurance: _____

Pertinent medical history (childhood diseases, illness, injuries, hospitalizations, surgery, etc. Please include dates, diagnosis, treatment received. Include lung, heart, muscle, etc.)

Please list and describe any current physical challenges and type of treatment (*PT, OT, speech*)

Please list present medications for applicant (a list of medications may be attached too)

Name of Medication	Dosage	Reason for Medication	Date Started

Does the applicant need supervision in taking medications: _____ Yes _____ No

If yes, explain: _____

Does the applicant have difficulty swallowing medication: Yes _____ No _____

Does the applicant have any drug or medication allergies: Yes _____ No _____

If yes, explain: _____

Date of Last Physical Exam (Enclose a copy of exam): _____

Name of Examining Physician: _____

Primary Care Physician: _____

How Long? _____

Clinic: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Date of Last Colonoscopy (Enclose a copy of exam): _____

Location Completed: _____

Date of Last Pap/Pelvic (Enclose a copy of exam): _____

Location Completed: _____

Date of Last Mammogram (Enclose a copy of exam): _____

Location Completed: _____

Date of Last Prostate (Enclose a copy of exam): _____

Location Completed: _____

Date of Last Dental Exam (Enclose a copy of exam): _____

Dental Clinic Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Does applicant wear dentures: Yes _____ No _____

Date of Last Vision Exam (Enclose a copy of exam): _____

Name of Examining Physician: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Findings and Recommendations _____

Does the applicant wear eye glasses: Yes _____ No _____

Date of Last Audiology Exam (Enclose a copy of exam): _____

Does applicant wear a hearing aid: Yes _____ No _____

Current Pharmacy: _____

Telephone Number: _____ Fax Number: _____

Preferred Hospital: _____

Date of Last Mantoux Test: _____

Results: Positive _____ Negative _____

If a history of a positive mantoux, date of last chest x-ray: _____

Record of Immunizations (Influenza, Pheumovac, etc) (immunizations may be attached):

Date of Last Tetanus Shot: _____ Hepatitis B Series Completed: Yes _____ No _____

DNR/DNI: Yes _____ No _____ N/A _____

Seizures

Petit Mal _____ Grand Mal _____ Other _____

Age of Onset: _____ Date of Last Seizure: _____

Frequency: _____

Is applicant followed by a Neurologist or Clinic: Yes _____ No _____

If yes, list Neurologist or Clinic: _____

Diet: _____

Does applicant have any food allergies? Yes _____ No _____

If yes, what? _____

Additional Comments:

Signature of individual completing application: _____

Phone Number: _____ Relationship to Applicant: _____

**Include a copy of the CSSP, CSSP Addendum, Self-Management Assessment, Individual Abuse Prevention Plan, most recent psychological, most recent exams and all current M.D orders. Please provide copies and/or originals of the following:*

- Medical Assistance Card
- Social Security Card
- Medicare Card
- State ID
- Prescription Drug Card
- Birth Certificate
- Guardianship papers

Scott County paperwork for out of state referrals for Hope Residence ONLY

- [MnCHOICES Information Form](#)
- [MnCHOICES Caregiver Assessment](#)
- [MnCHOICES Assessment Referral Form](#)