

VILLAGECARE AT 46 & TEN

**510 West 46th St.
New York, NY 10035
(212) 977-4600**

Application for Assisted Living Program (ALP)

Date: _____

Applicant Name: _____ Social Sec. # _____

Male Female Age: _____ Date of Birth: _____

Referred by: _____

Marital Status: Married Widowed Divorced Single (never married)

Children: _____

Current Residence: _____ Phone: _____

Own Home Hospital Nursing Home Other: _____

Nursing Home _____ Date of Admission: _____

Are you currently receiving home health services? Yes No

 If yes: Visiting Nurse Private Hired Help PCA/HHA

How many hours/days per week? _____ How long? _____

What services are provided? _____

Most Recent Hospitalization/Rehab? _____ Where? _____

Reason: _____

PRIMARY CONTACTS/SUPPORT PERSONS:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Phone: Home: _____ Phone: Home: _____

Work: _____ Work: _____

Cell: _____ Cell: _____

Attending Physician:

Name: _____

Address: _____

Phone: _____

Health Insurance:

Medicaid No.: _____

Medicare No.: _____

Prescription Plan/Medicare Part D Plan Name:

Other Health Care Providers:

Name: _____

Specialty: _____

Address: _____

Phone: _____

Prescription Plan/Medicare Part D Number:

HMO Plan Name: _____

Area Hospital/Clinic of Choice:

Personal Background

Wishes to be addressed as: _____

Where were you born/raised/lived most of your life?

Occupation: _____

Religious Affiliation (if any): _____ Place of Worship: _____

Have you ever been a client of Adult Protective Services? Yes No

If yes, when? _____

Health Care Proxy: Yes No Name: _____

Power of Attorney: Yes No Name: _____

DNR: Yes No Living Will: Yes No

Burial Instructions: _____

Can Applicant speak, read, and/or write English: Yes No

If no, indicate primary language: _____

Comments: _____

CONTINENCE STATUS/MANAGEMENT

Is the resident continent of urinary function? Yes No

Is the resident continent of bowel function? Yes No

IF THE ANSWER IS “NO” TO EITHER QUESTION, COMPLETE THIS SECTION, AS APPROPRIATE.

Urinary Incontinence	Bowel Incontinence
Less than once a week <input type="checkbox"/> Several times a week <input type="checkbox"/> Daily <input type="checkbox"/> Night Only <input type="checkbox"/> Day and night <input type="checkbox"/>	Less than once a week <input type="checkbox"/> Several times a week <input type="checkbox"/> Daily <input type="checkbox"/> Night Only <input type="checkbox"/> Day and night <input type="checkbox"/>
Current management techniques	Current management techniques
Prompting/reminding defers incontinence <input type="checkbox"/> Timed voiding defers incontinence <input type="checkbox"/> Uses incontinence pads/adult diapers: Day only <input type="checkbox"/> Night only <input type="checkbox"/> Day and night <input type="checkbox"/> Catheter (specify type) _____ Comments: _____ _____ Self-manage continence? <input type="checkbox"/> Yes <input type="checkbox"/> No	Uses incontinence pads/adult diapers: Day only <input type="checkbox"/> Night only <input type="checkbox"/> Day and night <input type="checkbox"/> Comments: _____ _____ Self-manage continence? <input type="checkbox"/> Yes <input type="checkbox"/> No

PHYSICAL FUNCTION

TASK	LEVEL OF ASSISTANCE	COMMENTS
<p>Eating: Ability to feed self meals And snacks)</p>	<p><input type="checkbox"/> Independent: Able to feed self Independently with or without assistive device</p> <p><input type="checkbox"/> Intermittent Assistance: Requires constant supervision and/or assistance</p> <p><input type="checkbox"/> Continual Assistance: Requires Constant assistance and/or supervision throughout meal</p> <p><input type="checkbox"/> Total Assistance: Unable to feed Self, needs to be fed. Unable to take Nutrients orally, requires enteral nutrition</p>	<p>Dentures: Upper <input type="checkbox"/> Yes <input type="checkbox"/> No Lower <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chewing Difficulties: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty Swallowing: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Modified consistency: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Specify: _____</p>
<p>Ambulation: (Ability to safely walk And move about once in a Standing position)</p>	<p><input type="checkbox"/> Independent: Walks and climbs stairs independently with or without assistive device</p> <p><input type="checkbox"/> Intermittent Assistance: Walks and Climbs and descends stairs with Minimal, intermittent assistance and/ or supervision</p> <p><input type="checkbox"/> Continual Assistance: Walks and Climbs stairs with constant supervision And/or assistance</p> <p><input type="checkbox"/> Total Assistance: Chairfast or Bedfast. Requires total assistance for mobility</p>	<p><input type="checkbox"/> Wheelchair</p> <p><input type="checkbox"/> Walker <input type="checkbox"/> Quad Cane</p> <p><input type="checkbox"/> Cane</p> <p><input type="checkbox"/> Other: _____</p> <p>Falls within the last 3 Months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequency #: _____</p> <p>Injury?: _____</p> <p>Comments:</p>

TASK	LEVEL OF ASSISTANCE	COMMENTS
<p>Transferring: (Moving from bed to chair, on/off toilet, in/out shower or tub)</p>	<p><input type="checkbox"/> Independent: Able to transfer independently with or without assistive device</p> <p><input type="checkbox"/> Intermittent Assistance: Transfers with minimal human assistance and/or supervision</p> <p><input type="checkbox"/> Continual Assistance: Unable to transfer but can bear weight and pivot when transferred by at least one person</p> <p><input type="checkbox"/> Total Assistance: Chairfast or bedfast, unable transfer, pivot, bear weight or turn self in bed</p>	<p>Comments:</p>
<p>Toileting: (Getting to/from and on/off the toilet, cleansing self after elimination and adjusting clothing)</p>	<p><input type="checkbox"/> Independent: Able to toilet independently with or without assistive device</p> <p><input type="checkbox"/> Intermittent Assistance: Able to toilet with minimal assistance and/or supervision</p> <p><input type="checkbox"/> Continual Assistance: Able to toilet with constant assistance and/or supervision</p> <p><input type="checkbox"/> Total Assistance: Unable to toilet. Requires total assistance with toileting.</p>	<p>Ostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments:</p>
<p>Bathing: (Getting in and out of tub or shower, washing and drying entire body)</p>	<p><input type="checkbox"/> Independent: Able to bathe or shower independently with or without assistive device</p> <p><input type="checkbox"/> Intermittent Assistance: Able to bathe or shower with minimal intermittent assistance and/or supervision</p> <p><input type="checkbox"/> Continual Assistance: Able to bathe or shower with constant assistance and/or supervision</p> <p><input type="checkbox"/> Total Assistance: Unable to use shower or tub. Bathed in bed at bedside</p>	<p>Comments:</p>

TASK	LEVEL OF ASSISTANCE	COMMENTS
<p>Dressing: (Getting clothes from closets and drawers, dressing and undressing, upper/lower body, Including buttons, snaps, zippers, socks and shoes)</p>	<p><input type="checkbox"/> Independent: Able to dress and undress independently with or without assistive device</p> <p><input type="checkbox"/> Intermittent Assistance: Able to dress and undress with minimal intermittent assistance and/or supervision</p> <p><input type="checkbox"/> Continual Assistance: Requires assistance throughout the dressing and undressing process</p> <p><input type="checkbox"/> Total Assistance: Requires another person to dress and undress upper and lower body</p>	<p>Comments:</p>
<p>Grooming: (Washing face, hair care, Shaving, teeth/denture, Fingernail care, eyeglasses care)</p>	<p><input type="checkbox"/> Independent: Able to groom self independently with or without assistive device</p> <p><input type="checkbox"/> Intermittent Assistance: Requires grooming Utensils to be set up and placed within reach</p> <p><input type="checkbox"/> Continual Assistance: Requires assistance Throughout the grooming process</p> <p><input type="checkbox"/> Total Assistance: Depends entirely upon Someone else for grooming</p>	<p>Comments:</p>
<p>Transportation: (Physical and mental ability to safely use a car taxi, or public transportation (bus, train, subway))</p>	<p><input type="checkbox"/> Independent: Able to independently drive a regular or adapted car; OR uses a regular or handicap accessible public bus, train or subway</p> <p><input type="checkbox"/> Independent: But requests facility perform task</p> <p><input type="checkbox"/> Intermittent Assistance: Able to ride in a car only when driven by another person; <u>AND/OR</u> due to physical, cognitive or mental limitations occasionally requires another person to accompany him/her when using a bus, train or subway</p>	

TASK	LEVEL OF ASSISTANCE	COMMENTS
Transportation cont'd	<input type="checkbox"/> Continual Assistance: Able to ride in a car only when driven by another person; <u>OR</u> able to use a bus or handicap van, train or subway only when assisted or accompanied by another person <input type="checkbox"/> Total Assistance: Unable to ride in a car, taxi, bus or van and requires transportation by ambulance	Comments:
Laundry: (Ability to do own laundry- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand)	<input type="checkbox"/> Independent: Able to independently take care of all laundry tasks <input type="checkbox"/> Independent: But requests facility perform task <input type="checkbox"/> Intermittent Assistance: Able to do only light laundry, such as minor hand wash or light washer loads. Needs assistance with heavy laundry, such as carrying large loads of laundry <input type="checkbox"/> Continual Assistance: Due to physical, cognitive or mental limitations, needs continual supervision and assistance to do any laundry <input type="checkbox"/> Total Assistance: <u>Unable</u> to do any laundry	Comments:
Housekeeping: (Ability to safely and effectively perform light housekeeping and heavier cleaning tasks)	<input type="checkbox"/> Independent: Able to independently perform all housekeeping tasks <input type="checkbox"/> Independent: But requests facility perform Task <input type="checkbox"/> Intermittent Assistance: Able to perform only light housekeeping (eg., dusting, wiping kitchen counters) tasks independently; <u>AND/OR</u> able to perform housekeeping tasks with intermittent assistance or supervision from another person <input type="checkbox"/> Continual Assistance: <u>Unable</u> to consistently perform any housekeeping tasks unless assisted by another person throughout the process	Comments:

TASK	LEVEL OF ASSISTANCE	COMMENTS
Housekeeping cont'd	<input type="checkbox"/> Total Assistance: <u>Unable</u> to effectively participate in any housekeeping tasks	
Shopping: (Ability to plan form, select and purchase items in a store and to carry them home or arrange delivery)	<input type="checkbox"/> Independent: Able to plan for shopping needs and independently perform shopping tasks, including carrying packages <input type="checkbox"/> Independent: But requests facility perform task <input type="checkbox"/> Intermittent Assistance: Able to do only light shopping and carry small packages, but needs someone to do occasional major shopping <input type="checkbox"/> Continual Assistance: <u>Unable</u> to go shopping alone, but can go with someone to assist; <u>OR</u> unable to go shopping but is able to identify items needed, place orders, and arrange for home delivery <input type="checkbox"/> Total Assistance: Needs someone to do all shopping and errands	Comments:
Ability to use a Telephone: (Ability to answer the telephone, dial numbers, and <u>effectively</u> use the telephone to communicate)	<input type="checkbox"/> Independent: Able to dial numbers and Answers calls appropriately and as desired <input type="checkbox"/> Independent: But requests facility perform Task <input type="checkbox"/> Intermittent Assistance: Able to use a specially adapted telephone (i.e. large numbers on the dial pad, teletype phone for the deaf) and call essential numbers; able to answer the telephone and carry on a normal conversation but has difficulty with placing calls; able to answer the telephone only some of the time or is able to carry on only a limited conversation <input type="checkbox"/> Continual Assistance: Unable to make calls or answer the telephone at all, but can listen if assisted with equipment <input type="checkbox"/> Total Assistance: Totally unable to use the Telephone. Requires someone to make calls.	Comments:

Why does applicant require assisted living at this time? _____

Applicant's statement of own needs, desires, fears, expectations, etc.

Applicant Signature

Date

Application Completed by:

Relation

Date

Please mail this application to:

Elaine Knight
VillageCare at 46 and Ten
510 West 46th Street
New York, NY 10036