

Location: _____

Form #157AL – 02/15

Case #: _____

The Center ASSISTED LIVING INTAKE CHECKLIST

Name: _____ Date of Birth _____

All documents should be submitted to Records Management within 5 working days prior to the entry date.

PRE – ADMISSION DOCUMENTATION REQUIREMENTS

Documents Required Before Starting

- _____ Application for Services #145
- _____ Admission Funding Data #151
- _____ Copy of Letter of Guardianship and
Verification of annual renewal (if applicable)
- _____ DMR – Determination of Mental Retardation **or**
- _____ Psychological Evaluation (*less than 10 yrs old*)
- _____ Physical Examination #04 (*less than 1 yr old*)
- _____ Admissions Medication History #18
- _____ Physician's Orders #08 (*if applicable*)
- _____ Copy of TB Test #76 (*less than 1 year old*)
- _____ Copy of DPT/td #120 (*less than 10 yrs old*)

Additional Documents – if available

- _____ Copy of Birth Certificate
- _____ Copy of Texas Identification Card
- _____ Copy of Social Security Card
- _____ Copy of Medicaid Card
- _____ Copy of Medicare Card
- _____ Copy of HMO/PPO/Other Insurance Card
- _____ Copy of SSI Award Letter

MOVE IN DOCUMENTATION REQUIREMENTS

(Initial Assisted Living Support Plan packet to include the following documents.)

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> _____ Initial Assisted Living Services and Supports Plan #12AL _____ Agreement for Residential Services _____ Financial Authorization Form #59 _____ Emergency Authorization #41 _____ Advanced Directives #45 _____ Medication Policy #06 _____ Physician's Orders for Self Administration of Medication #80 _____ Resident's Rules #101 _____ Residential Rights #127 | <ul style="list-style-type: none"> _____ Rights Acknowledgment #111 _____ Notice Of Privacy Practices #110 _____ Program Information Receipt #113 _____ 24 Hour Activity Schedule #128 _____ Residential Training Objective #25 (<i>if applicable</i>) _____ Residential Service Objective #38 (<i>if applicable</i>) _____ Full Body Photo _____ Head and Chest Photo |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

30 DAY ASSESSMENT DOCUMENTATION REQUIREMENTS

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> _____ 30 Day Assessment Interim Staffing #102 _____ Residential Personal Skills Profile #160 _____ Inventory of Belongings (Female) #162 _____ Inventory of Belongings (Male) #163 _____ Comprehensive Nursing Assessment #8584 | <p style="text-align: center;"><u>(ALSO IF APPLICABLE)</u></p> <ul style="list-style-type: none"> _____ Day Program Personal Skills Profile #107 _____ Day Program Training Objective #25 _____ Day Program Accountability Chart #13M |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

OTHER DOCUMENTS RECEIVED

- | | |
|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> _____ Other _____ _____ Other _____ | <ul style="list-style-type: none"> _____ Other _____ _____ Other _____ |
|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

THE CENTER

APPLICATION FOR SERVICES / ENROLLMENT FORM

GENERAL INFORMATION

DATE OF APPLICATION: _____

NAME OF APPLICANT: _____
Last Name First Name Middle Initial

PRESENT ADDRESS: Street Address: _____
City: _____ State: _____ Zip: _____

PHONE NUMBER: [Home] (____) _____ [Emergency] (____) _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

DATE OF BIRTH: _____ **AGE:** ____ **S/S #** _____ **SEX:** Male Female

MARITAL STATUS: Single Married Divorced Widowed

PRIMARY LANGUAGE: English Spanish Other, specify: _____

COMMUNICATION MODE: Verbal Gestures Vocalizations Sign Language

COMMUNICATION DEVICE(S): _____ **RELIGION:** _____

HAIR: _____ **EYE:** _____ **HEIGHT:** _____ **WEIGHT:** _____ **ETHNICITY:** _____

CLIENT OR GUARDIAN _____ **DATE:** _____
Signature

FOR OFFICE USE ONLY

PROGRAMS APPLYING FOR

- | | | | |
|--------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AAC - West Dallas | <input type="checkbox"/> Cullen - Assisted Living
Room # _____ | <input type="checkbox"/> Willow River Farm
House # _____ | <input type="checkbox"/> HCS Foster Companion Care |
| <input type="checkbox"/> ATES – Day Habilitation | <input type="checkbox"/> Cullen - Independent Living
Room # _____ | <input type="checkbox"/> WRF-Assisted Living
House # _____ | <input type="checkbox"/> HCS Supervised Home Lvg |
| <input type="checkbox"/> ATES - Vocational | | <input type="checkbox"/> WRF-Day Program | <input type="checkbox"/> HCS Residential Supervised |
| <input type="checkbox"/> ATES – Young At Heart | | | <input type="checkbox"/> HCS Supported Living |

FUNDING

- Private Pay TXHML ICF/MR The Center HCS
- Medicaid MCO Contract Other HCS: _____

DATE FUNDING VERIFIED by ADMISSIONS COORDINATOR: _____

ADMISSION DECISION

Date Applicant Informed of Decision: _____
 Approved Approved - Waiting List Not Approved

Enter Date: _____ Entered on List: _____ Reason: _____

Assigned Program Coordinator: _____

Signature of Social Worker Signature of Dept. Director/Manager Signature of Chief Operating Officer

THE CENTER APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: _____ DOB: _____ DATE: _____

FAMILY/CONTACTS

NAME OF FATHER: _____

Describe Contact: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____) _____ [Work] (____) _____

Phone: [Cell] (____) _____ **Email Address:** _____

NAME OF MOTHER: _____

Describe Contact: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____) _____ [Other/Emergency] (____) _____

Phone: [Cell] (____) _____ **Email Address:** _____

NAME OF EMERGENCY CONTACT: _____

Relationship to Applicant: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____) _____ [Other/Emergency] (____) _____

Phone: [Cell] (____) _____ **Email Address:** _____

NAME OF EMERGENCY CONTACT: _____

Relationship to Applicant: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: [Home] (____) _____ [Other/Emergency] (____) _____

Phone: [Cell] (____) _____ **Email Address:** _____

THE CENTER APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: _____ DOB: _____ DATE: _____

BACKGROUND

PLACE OF BIRTH: City: _____ County: _____ State: _____

US CITIZENSHIP Yes No **LEGAL STATUS** Competent Incapacitated

if has a court appointed Guardian:

Name of Guardian: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: [Home] (____) _____ [Other/Emergency] (____) _____

Date Appointed by Court: _____ Court Case Number: _____

County: _____ State: _____

INSURANCE

MEDICAID

- Yes, Number (#): _____
- No, have applied and been denied
- No, have never applied

MEDICARE

- Yes, Number (#): _____
- No, have applied and been denied
- No, have never applied

HMO/PPO

- Yes, Policy Number (#): _____
Company Name: _____
- No

LIFE INSURANCE

(needed only if applying
for a residential program)

- Yes, Policy Number (#): _____
Company Name: _____
- No

BURIAL INSURANCE

(needed only if applying
for a residential program)

- Yes, Policy Number (#): _____
Company Name: _____
- No

INCOME

ESTIMATED ANNUAL INCOME OF APPLICANT: _____

PRIMARY SOURCE OF INCOME: *(check one)*

- SSI Wages Other, specify: _____

OTHER MEANS OF FINANCIAL SUPPORT: _____

DESCRIBE APPLICANT'S PARTICIPATION IN COMMUNITY/NEIGHBORHOOD:

THE CENTER APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: _____ DOB: _____ DATE: _____

MOBILITY/SELF CARE

Mobility *(check one)*

- Walks Independently Walks with Assistance from Others
 Uses Wheelchair Independently Uses Wheelchair with Assistance from Others

Describe/List Any Adaptive Equipment Used for Mobility: _____

Describe Assistance Needed to Get from One Place to Another: _____

Eats Meals Independently Yes No, please describe help needed: _____

Bathes Independently Yes No, please describe help needed: _____

Dresses Independently Yes No, please describe help needed: _____

THE CENTER APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: _____ **DOB:** _____ **DATE:** _____

Uses Rest Room Independently Yes No, please describe help needed: _____

Describe Any Other Assistance Needed/Comments: _____

MEDICAL/HEALTH CARE

PRIMARY PHYSICIAN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: [Office] (____) _____ [Fax] (____) _____

KNOWN ALLERGIES (*food, medication, other*): _____

EXISTING MEDICAL CONDITIONS/DIAGNOSES: _____

SEIZURES No Yes, please explain: _____

HEARING IMPAIRMENT No Yes, please explain: _____

THE CENTER APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: _____ DOB: _____ DATE: _____

VISION IMPAIRMENT No Yes, please explain: _____

ADAPTIVE EQUIPMENT/POSITIONING No Yes, please explain: _____

TAKES MEDICATIONS INDEPENDENTLY Yes No, please explain: _____

MEDICAL/HEALTH CARE

CURRENT MEDICATIONS

Medication	Date Prescribed	Reason for Use

MEDICAL HISTORY please list/describe hospitalizations and significant illnesses

Date	List or Describe Hospitalization or Surgery or Illness

**THE CENTER
APPLICATION FOR SERVICES / ENROLLMENT FORM**

NAME: _____ **DOB:** _____ **DATE:** _____

ADDITIONAL COMMENTS RELATED TO MEDICAL/HEALTH CARE: _____

FOR OFFICE USE ONLY

Advance Directive No Yes (attach copy) DNR Order No Yes (attach copy)

INTERACTIONS

DESCRIBE HOW APPLICANT INTERACTS WITH OTHERS: _____

DESCRIBE BEST WAY TO INTERACT WITH THE APPLICANT: _____

DESCRIBE THINGS THAT THE APPLICANT LIKES OR THAT MOTIVATE HIM/HER:

THE CENTER APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: _____ DOB: _____ DATE: _____

DESCRIBE APPLICANT'S ABILITY TO MAKE CHOICES: _____

DESCRIBE ANY SIGNIFICANT BEHAVIORS: _____

EDUCATION/SERVICES/EMPLOYMENT

EDUCATION (schools attended)

Name of School	City	State	Dates Attended From/To	Highest Grade Completed

CURRENT SERVICES *(includes residential, vocational, job training, in-home care)*

Date Services Began	Type of Service(s)	Agency Providing the Service(s)	City	State

THE CENTER APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: _____ DOB: _____ DATE: _____

PREVIOUS SERVICES *(includes residential, vocational, job training, in-home care)*

Dates of Service From/To	Type of Service(s)	Agency that Provided the Service(s)	City	State

CURRENT EMPLOYMENT

Name of Employer	Job Title	Hire Date	Wage	Location

PREVIOUS EMPLOYMENT

Name of Employer	Job Title	Dates of Employment	Wage	Location

TRANSPORTATION

TRANSPORTATION *(check all that apply)*

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Uses City Bus/Cab Independently
<input type="checkbox"/> Family/Friends Provide Transportation
<input type="checkbox"/> Operates Own Vehicle (Car/Bike) | <input type="checkbox"/> Uses Para Transit (Metro Lift)
<input type="checkbox"/> Agency (group home) Provides Transportation
<input type="checkbox"/> Other, _____ |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Comments: _____

THE CENTER APPLICATION FOR SERVICES / ENROLLMENT FORM

NAME: _____ DOB: _____ DATE: _____

Has the Applicant ever been Convicted (or adjudicated) of a public offense? No Yes
If yes, will the conviction interfere with the admission at The Center? No Yes

If yes, please explain: _____

Please submit documents requested on the Application for Services Documentation Checklist.

Your application will not be considered complete until all documents have been given to The Center's Admissions Coordinator.

Please contact The Center's Admissions Coordinator (713) 525-8318 with any questions or for assistance.

I agree that the information provided is, to the best of my ability, accurate and complete.

Applicant Signature

Date

Guardian Signature

Date

Witness Signature

Date

THE CENTER ADMISSION FUNDING DATA

NAME OF INDIVIDUAL: _____
Last Name First Name Middle Initial

PRESENT ADDRESS: Street Address: _____
 City: _____ State: _____ Zip: _____

PHONE NUMBER: [Home] (____) _____ [Other/Emergency] (____) _____

DATE OF BIRTH: _____ **GENDER:** Male Female

SOCIAL SECURITY NUMBER: _____

PROGRAM(S)	LOCATION CODE	ADMISSION DATE	FUNDING SOURCE(S)	FUNDING AMOUNT
Adult Activity Center	AAC			
ATES - Caning	CAN			
ATES - West Dallas Day Habilitation Classroom	DHC			
ATES - West Dallas Day Habilitation Workshop	DHW			
ATES - West Dallas Vocational Workshop	WDW			
ATES - Young At Heart	YAH			
Cullen - Assisted Living	AL			
Cullen - Independent Living	IL			
Willow River Farm - Residential	WRF			
Willow River Farm - Assisted Living	WRFAL			
Willow River Farm – Day Habilitation	WRFDH			

INVOICE MAILING ADDRESS:
 Street Address: _____
 City: _____ State: _____ Zip: _____

COMMENTS: _____

Signature of Program Director/Manager **Date**

Signature of Admission Coordinator **Date**

Send a copy to Accounting within 5 working days prior to entry date; original submitted with Intake Checklist to Records.

Location: _____

Form #18 – 03/79
Revised 09/12

Case #: _____

The Center

ADMISSION MEDICATION HISTORY

NAME: _____ DATE OF BIRTH: _____

List any allergic reactions to medications: _____

A. CURRENT MEDICATIONS:

Name of Medication Presently Prescribed	Reason for Medication	Date Prescribed	Prescribing Doctor	No. of Times per Day	How Much Medicine Each Time	Where is Medication Taken

B. PAST MEDICATIONS

Name of Medication Prescribed	Reason for Medication	Date Prescribed	Date Discontinued

SIGNATURE: _____
(Individual / Parent / Guardian)

DATE: _____

Location: _____
Case #: _____

The Center
3550 West Dallas Houston, Texas 77019
(713) 525-8400

REPORT OF PHYSICAL EXAMINATION

NAME: _____ DATE OF BIRTH: _____ M _____ F _____

SECTION I - Condensed Medical History:

Known Allergies:

SECTION II - Medication Presently Prescribed and Reason for Use:

SECTION III - Results of Physical Examination:
HT: _____ WT: _____ PULSE RATE: _____ BLOOD PRESSURE: _____
NUTRITIONAL STATUS: _____ Good _____ Fair _____ Poor - Recommendations (DIET):

EYES: _____ Normal _____ Abnormal - Comments: _____

Describe ability to see: _____

Visual Acuity: R. 20/ _____ L. 20/ _____ With glasses: R. 20/ _____ L. 20/ _____

EARS: _____ Normal _____ Abnormal - Comments: _____

Describe ability to hear: _____

NOSE: _____

MOUTH: _____

THROAT & NECK: _____

BREAST: _____

THORAX & LUNGS: _____

Location: _____
Case #: _____

NAME: _____

DATE OF BIRTH: _____

CIRCULATORY SYSTEM: Heart _____

EXTREMITIES: _____

ABDOMEN: _____

HERNIAS: _____

GENITO-URINARY-GYNECOLOGICAL & RECTAL: _____

OSSEOUS & MUSCULAR SYSTEM: _____

SKIN: _____

NEUROLOGICAL: _____

MENTAL STATUS: _____

If on psychoactive medication, note any Side Effects and results of Assessment of Involuntary Movement:

HISTORY OF SEIZURES: _____ No _____ Yes, list type: _____

If on anticonvulsant medication, comment on any side-effects noted:

DIAGNOSTIC FINDINGS AND/OR IMPRESSIONS: _____

Is this person free from communicable diseases? _____ YES _____ NO - If No, Explain: _____

Is this person able to attend program without restrictions? _____ YES _____ NO - If No, Specify: _____

OTHER EXAMINATIONS/LABORATORY TESTS NEEDED: _____

(Forward results when completed)

Physician's Signature

Print or Type Physicians Name

Full Address and Telephone Number

Date of Examination

FOR AGENCY USE ONLY:

Reviewed by: _____

Date: _____

RESIDENTS ONLY:

The above results have been explained to me.

Resident's Signature

Location: _____

Case #: _____

The Center
3550 West Dallas
Houston, Texas 77019
(713) 525-8400

Form #8 - 08/84
Revised 09/12
Non-Residential Services

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION

Name: _____ Birth Date: _____ Date: _____

Diagnosis: _____

Allergies: _____

Reason for referral to physician: _____

Diet: _____

CURRENT ORDERS: Signature of physician indicates these orders are renewed unless discontinued in new order section below.

<u>Medication / Strength</u>	<u>Route</u>	<u>Directions</u>	<u>No. Units / Stop Order Date</u>	<u>Medication / Strength</u>	<u>Route</u>	<u>Directions</u>	<u>No. Units / Stop Order Date</u>
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_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

NEW ORDERS: 1) Generic Equivalent approved for use on all legend and non-legend medications unless otherwise indicated. 2) Please indicate calendar-date stop order for each

medication ordered. Medications for behavior management must, according to standards under which The Center operates, have a calendar date stop order of 30 days or less.

<u>Medication / Strength</u>	<u>Route</u>	<u>Directions</u>	<u>No. Units / Stop Order Date</u>	<u>Medication / Strength</u>	<u>Route</u>	<u>Directions</u>	<u>No. Units / Stop Order Date</u>
------------------------------	--------------	-------------------	------------------------------------	------------------------------	--------------	-------------------	------------------------------------

_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Activity Restrictions: _____

TEST RESULTS: Please indicate any laboratory tests, x-rays, blood levels, etc. performed. You will be called for results if they are unavailable at time of this report (continue on reverse side if necessary). _____

Return Appointment Date / Time: _____ / _____

Physician's Signature: _____ Date: _____

(Please print or type the Physician's Name, Office Address & Telephone Number on the line below.)

Signature of Nurse Receiving Orders (LVN/RN) _____ Date / Time _____ / _____

This is your permission to administer the above medications, treatments, and/or procedures as requested by physician.

Signature of Individual / Guardian: _____ Date: _____

Location: _____

Form #76 – 03/05

Case # _____

Revised 09/12

The Center
3550 West Dallas - Houston, Texas 77019
MAIN 713-525-8400 FAX 713-525-8493

ANNUAL TB TEST

INDIVIDUAL _____ DATE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

Annual TB skin testing is recommended for all individuals served at The Center. Please provide your primary care physician with this form to have your skin test administered and/or read. Should the results of your skin test be positive, you are required to have a chest x-ray before you may return to The Center. Also, if you are a known positive reactor, you should have a chest x-ray every two years, or as often as recommended by your primary care physician.

Know the signs and symptoms of TB, which include but are not limited to: **PRODUCTIVE AND PROLONGED COUGH, COUGHING UP BLOOD, FEVER, CHILLS, LOSS OF APPETITE, WEIGHT LOSS, FATIGUE/WEAKNESS, OR NIGHT SWEATS.**

() ANNUAL SKIN TEST () CHEST X-RAY () EXEMPT

Once the TB test and/or Chest X-Ray have been read and the results recorded on this form, **please return this form to The Center / Records Department at 3550 West Dallas, Houston, Texas 77019.**

LICENSED NURSING STAFF ONLY:

DATE OF TEST: _____ Lot # _____

SITE: LEFT _____ RIGHT _____ Expires: _____

ADMINISTERED BY: _____

DATE READ: _____ **(Results of skin test must be read 48-72 hours after the test is administered.)**

RESULTS: POSITIVE _____ Millimeters NEGATIVE _____

READ BY: _____

CHEST X-RAY RESULTS (if applicable)

LICENSED STAFF ONLY:

DATE OF X-RAY: _____ ADMINISTERED BY: _____

RESULTS: POSITIVE _____ NEGATIVE _____ READ BY: _____

Original: Individual Master Record