MALACHI HOUSE

A loving home for life's last journey

Standards for Admission

Will accept residents with:

DIAGNOSIS:

Lithium with lab monitoring

Psych diagnoses managed by medication

MRSA wound

CARE:

Peg tubes with bolus feeding only

Colostomy

Urostomy

Chest tubes that hospice staff manages

Foley catheter

Injections done by hospice staff

Wounds with simple dressing changes

Trach without suction

O2 Therapy/CPAP/BIPAP

Will not accept residents with:

DIAGNOSIS:

Insulin dependent diabetics

Blood sugar monitoring

Confused residents that wander

MRSA lung

Active TB

CARE:

Suction

Ventilator support

Active alcohol or drug addiction

Electric wheelchair or scooter

Applicant must have:

Limited financial resources. Each will be considered on an individual basis.

No willing, available, or competent caregiver.

Care provided by a hospice team.

DNR-CC order.

Results of a chest X-Ray or TB test performed within the past 6 months.

Funeral arrangements made in advance.

Office Use Only

Resident #:____________________

Admit Date: ____________________

Expired: ____________________

Discharged: ____________________

2810 Clinton Avenue
Cleveland, OH 44113
216.621.8831 phone
216.621.8841 fax

APPLICATION FOR RESIDENCY

Malachi House of Hope, created out of a Christian sense of ministry, serves persons who are terminally ill, without cost or regard to gender, race, religion or national origin. This home ministers to individuals who need an available caregiver, who have limited or no financial resources and are in need of special home care in the final stages of life. A trained staff and volunteers provide spiritual, emotional, and physical support with the assistance of a hospice team.

Name:____________________ Phone: ____________________

Address: ____________________

SSN: ____________________ Date of Birth: ____________________

Age: __________ Sex: __________ Ethnicity:____________________

DIAGNOSIS:

What is your primary diagnosis?: ____________________

Do you have:

Tuberculosis	Yes	No	Insulin dependent diabetes	Yes	No
Feeding Tube	Yes	No	I.V.	Yes	No
Do you require:			Sub Q Medication	Yes	No
Respirator/Trach	Yes	No	Injectable Medication	Yes	No

WE DO NOT TAKE INSULIN DEPENDENT/GLUCOSE-MONITORED RESIDENTS

HOSPICE:

Are you in a hospice program now? Yes No

If no, are you willing to enter a hospice program? Yes No

If yes, what is the name of the hospice? ____________________

CAREGIVER:

Do you have a caregiver now? Yes No

If yes, who is your caregiver? ____________________

Caregiver phone: ____________________ Caregiver address:____________________

If your caregiver is no longer willing or able to take care of you please explain:

POWER OF ATTORNEY:

Do you have a P.O.A.? Yes No P.O.A Phone: ____________________

P.O.A. Name: ____________________

P.O.A. Address: ____________________

ALL AREAS MUST BE COMPLETED

FINANCIAL FORM

(This information will be used **ONLY** to determine eligibility)

Medicare #:____________________________ Medicaid #:____

Total monthly income: $_____________ from ◯ SSI or SSD ◯ Pension ◯ other

Total monthly expenses: $_____________

Savings account Yes No If yes, current balance: $_____________

IRA, 401k, Investments Stocks, Bonds Yes No If yes, current balance: $_____________

Checking Account Yes No If yes, current balance: $_____________

Do you own: home/property? Yes No If yes, estimated value: $_____________

1st mortgage balance: $_____________ 2nd mortgage balance if applicable $_____________

ATTACHMENTS:

The following items MUST be attached to the application:

Completed & Signed DNR Form

Current Chest X-Ray (within 3 months)

Malachi House Transfer Form

History & Physical

REPORT CALLED ON DAY OF ADMISSION

IS RESIDENT A VETERAN? Yes No

FUNERAL HOME ARRANGEMENTS NEED TO BE IN PLACE BEFORE ADMISSION:

Name of Funeral Home: ____

Address: ____

Telephone: ____

ALL RESIDENTS WILL BE RE-EVALUATED EVERY SIX MONTHS

I understand and agree that my residency at Malachi House of Hope may be re-evaluated at any time for changes in diagnosis, prognosis, or behavior. The information I have provided here is true and accurate to the best of my knowledge.

______________________________________ ______________________________________

Applicant Person Signing for Applicant

_________________________ _________________________

Date

Office Use Only

Approved By: ____ Date: _____________________

ALL AREAS MUST BE COMPLETED

MALACHI HOUSE

A loving home for life's last journey

REFERRAL INFORMATION FORM

Patient Name: ______________________ SSN: ______________

Home Address: ______________________

City: ______________ State: __________ Zip: __________

County: ______________ Date of Birth: ______________

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Religion: ______________ Church: ______________

MEDICAL INFORMATION:

Principal Diagnosis (include date of onset): ______________________

Other Diagnosis: ______________________

Prognosis: ______________________

Allergies: ______________________

Brief history/course of treatments/tests/surgeries (include dates): ______________________

Test:	**Date:**	**Result:**	
Chest X-Ray	________	______________	ATTACH A COPY TO THIS APPLICATION
PPD	________	______________	ATTACH A COPY TO THIS APPLICATION

MRSA / E ◯ Yes ◯ No Site: ______________________

MEDICATION

Diet: ______________ Consistency: ______________

Referral Made By: ______________ Date: ______________

ALL AREAS MUST BE COMPLETED

SOCIAL SERVICE INFORMATION FORM

PRESENT PATIENT LOCATION:

If not in hospital, present patient location: ______________________________

Present address: ______________________________

Contact: ______________________________ Phone: ______________________________

POWER OF ATTORNEY:

Name: ______________________________

Address: ______________________________

Relationship: ______________________________ Phone: ______________________________

FAMILY / FRIEND / GUARDIAN:

Name:	Relationship:	Address:	Phone:

COMMUNITY AGENCIES ACTIVE WITH PATIENT:

Agency Name:	Staff:	Phone:

SOCIAL SERVICE ASSESSMENT / RESIDENT OR FAMILY: Please comment on each

Family relationship/support: ______________________________

Home environment (physical & social): ______________________________

Over the past six months have the resident, family, or hospice team noticed a problem with:

- ◯ Lice: ______________________________
- ◯ Bedbugs: ______________________________
- ◯ Cockroaches: ______________________________
- ◯ Other: ______________________________

Cognitive/Emotional/Coping Status: ______________________________

Additional problem areas: ______________________________

History of alcohol abuse: ______________________________

History of drug abuse: ______________________________

Psych history: ______________________________

History of domestic violence: ______________________________

SW/RN signature: ______________________________

ALL AREAS MUST BE COMPLETED

RESIDENT PSYCHO-SOCIAL HISTORY

Patient Name: ____________________ Admit Date: ____________
Social Worker: ____________________ Phone: ____________
Diagnosis: ____________________
Other disease processes (physical/psychological): ____________________

FUNCTION LEVEL:
Physical: ____________________
Psycho-social: ____________________

MENTAL:
- ◯ Alert
- ◯ Lethargic
- ◯ Comatose
- ◯ Oriented
- ◯ Disoriented
- ◯ Confused
- ◯ Dementia
- ◯ Forgetful

____
____
____
____

AFFECT:
- ◯ Cheerful
- ◯ Superficially Cheerful
- ◯ Calm
- ◯ Hostile
- ◯ Flat, Blunted
- ◯ Fearful
- ◯ Anxious/Agitated
- ◯ Depressed
- ◯ Tearful
- ◯ Other (explain)

____
____

ATTITUDE & BEHAVIOR:
- ◯ Disruptive
- ◯ Helpful
- ◯ Thoughtful
- ◯ Withdrawn
- ◯ Resistive
- ◯ Immature / Regressed
- ◯ Aggressive
- ◯ Preoccupied
- ◯ Manipulative
- ◯ Seeks reassurance
- ◯ Seeks attention
- ◯ Anxious
- ◯ Other (explain)

____
____
____
____
____
____

ACTIVITY:
- ◯ Ambulatory Ad Lib
- ◯ Ambulatory w/Assist
- ◯ Assistive Device
- ◯ Transfer to bed
- ◯ Bedbound

____

VERBILIZATION:
- ◯ Non-Verbal
- ◯ Verbalized only when questioned
- ◯ Verbalized spontaneously
- ◯ Other (explain)

____
____

RELEVANT HISTORY, CURRENT DYNAMICS, CURRENT ISSUES:
____
____
____
____

FAMILY:
Spouse: ____________ Parents: ____________
Children: ____________________
____
Siblings: ____________________
____
Other: ____________________

ALL AREAS MUST BE COMPLETED

MALACHI HOUSE

A loving home for life's last journey

PATIENT NAME: ______________________________

NURSING SUMMARY:

Cardio-Pulmonary:

Temp: __________ ◯ O ◯ Ax ◯ R ◯ Secretions
Pulse: __________ ◯ AP ◯ R ◯ Quality Describe: ____________________________
BP: __________ ◯ R ◯ L ◯ Tracheostomy
Resp: __________ Depth and Quality: ____________ Size: __________ Type:_ _______________
Oxygen Used/Breathing Treatment: ____________________ Rate: _________________ Method: _________________________________

NUTRITION / HYDRATION:

Height: ________ Diet: ◯ Feeds Self ◯ Dehydration
Weight: ________ _____________________ ◯ Assist Feed ◯ Edema
◯ Teeth ◯ Total Feed ◯ Nausea
◯ No Teeth Consistency: ◯ Hyperalmentation ◯ Vomiting
◯ Dentures Type _____________________ ◯ Feeding Tube Type ◯ Dysphagia
◯ Denture with Patient Date Inserted: ______________ ◯ Poor Appetite

SENSORY / COMFORT:

VISION:	**HEARING:**	**SPEECH:**	**COMFORT:**
◯ Adequate	◯ Adequate	◯ Good	Pain ◯ Yes ◯ No
◯ Poor	◯ Poor	◯ Difficult	Where/When: __________________
◯ Blind	◯ Deaf	◯ Unable	___________________________
◯ Glasses	◯ Aid	Language:	**SENSORY AIDS:**
◯ Contacts	In Ear __________	____________________	PT has them ◯ Yes ◯ No
			PT uses them ◯ Yes ◯ No

PSYCHOSOCIAL:

MENTAL STATUS:	**BEHAVIOR:**	**AFFECT:**	**SUPPORTS:**
◯ Alert	◯ Wanders	◯ Flat	◯ Lives with others
◯ Lethargic	◯ Cooperative	◯ Calm	◯ Lives alone
◯ Comatose	◯ Combative	◯ Anxious	◯ Gets help from others
◯ Oriented	◯ Forgetful		
◯ Disoriented	◯ Sleep Problems		
◯ Confused	◯ Other – specify: ____________________		

ELIMINATION:

BLADDER:	**BOWEL:**	**TOILETING:**	
◯ Continent	◯ Continent	◯ Independent	◯ Toilet
◯ Incontinent	◯ Incontinent	◯ Dependent	◯ Bedpan
◯ Retention	◯ Constipation	◯ Ostomy	◯ Catheter
◯ Frequency	◯ Diarrhea	Type:____________	◯ Foley
◯ Dribbling	Last BM: __________	Appliance: _________	◯ Urostomy

SKIN:

Skin Intact ◯Yes ◯No
Describe any impairments:
Size: _____________ Site: ______________ Drainage: ____

HYGEINE / MOBILITY:

				Equipment / # Persons Used:
Oral Care:	◯ Independent	◯ Assist	◯ Total Dependent	_______________________
Bathing:	◯ Independent	◯ Assist	◯ Total Dependent	_______________________
Dressing:	◯ Independent	◯ Assist	◯ Total Dependent	_______________________
Wheelchair:	◯ Independent	◯ Assist	◯ Total Dependent	_______________________
Transfer:	◯ Independent	◯ Assist	◯ Total Dependent	_______________________
Ambulation:	◯ Independent	◯ Assist	◯ Total Dependent	_______________________
◯ Amputation	◯ Contractures	◯ Paralysis	◯ Paresis	◯ Other _______________________

SAFETY:

◯ Fainting ◯ Dizziness ◯ Headaches ◯ Seizures ◯ Weakness

Signature: ____ **Date**: ____

ALL AREAS MUST BE COMPLETED