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 per State of Ohio form

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

Funeral arrangements made in advance.

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2810 Clinton Avenue
Cleveland, OH 44113
216.621.8831 phone
216.621.8841 fax

Office Use Only
Resident #:_____
Admit Date: _____
Expired: _____
Discharged: _____

APPLICATION FOR RESIDENCY

Malachi House, 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 health care P.O.A.? Yes_____ No_____ HC P.O.A Phone: _____

General/Financial Health Care 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

Malachi House Transfer Form

Current Chest X-Ray (within 6 months)

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: _____

I understand and agree that my residency at Malachi House 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: _____

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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 ◯ Yes ◯ No Site: _____

MEDICATION

Does patient refuse to take medications: Yes____ No ____ Sometimes_____
Diet: _____ Consistency: _____
Referral Made By: _____ Date: _____

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SOCIAL SERVICE INFORMATION FORM

PRESENT PATIENT LOCATION:

If not in hospital, present patient location: _____

Present address: _____

Contact: _____ Phone: _____

HEALTH CARE 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:_____

Sitter/Restraints-Free minimum of 24 Hours: _____

Cognitive/Emotional/Coping Status: _____

Additional problem areas: _____

History of Smoking: _____

History of alcohol abuse: _____

History of drug abuse: _____

Psych history: _____

History of domestic violence: _____

SW/RN signature: _____

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RESIDENT PSYCHO-SOCIAL HISTORY

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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: _____

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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**: _____

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