## Standards for Admission

<table>
<thead>
<tr>
<th>Will accept residents with:</th>
<th>Will not accept residents with:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIAGNOSIS:</strong></td>
<td><strong>DIAGNOSIS:</strong></td>
</tr>
<tr>
<td>Lithium with lab monitoring</td>
<td>Insulin dependent diabetics</td>
</tr>
<tr>
<td>Psych diagnoses managed by medication</td>
<td>Blood sugar monitoring</td>
</tr>
<tr>
<td>MRSA wound</td>
<td>Confused residents that wander</td>
</tr>
<tr>
<td></td>
<td>MRSA lung</td>
</tr>
<tr>
<td></td>
<td>Active TB</td>
</tr>
<tr>
<td><strong>CARE:</strong></td>
<td><strong>CARE:</strong></td>
</tr>
<tr>
<td>Peg tubes with bolus feeding only</td>
<td>Suction</td>
</tr>
<tr>
<td>Colostomy</td>
<td>Ventilator support</td>
</tr>
<tr>
<td>Urostomy</td>
<td>Active alcohol or drug addiction</td>
</tr>
<tr>
<td>Chest tubes that hospice staff manages</td>
<td>Electric wheelchair or scooter-</td>
</tr>
<tr>
<td>Foley catheter</td>
<td></td>
</tr>
<tr>
<td>Injections done by hospice staff</td>
<td></td>
</tr>
<tr>
<td>Wounds with simple dressing changes</td>
<td></td>
</tr>
<tr>
<td>Trach without suction</td>
<td></td>
</tr>
<tr>
<td>O2 Therapy/CPAP/BIPAP</td>
<td></td>
</tr>
</tbody>
</table>

### 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 less than 6 months old

Funeral arrangements made in advance.
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
- Feeding Tube  Yes  No
- Insulin dependent diabetes  Yes  No
- I.V.  Yes  No

Do you require:
- Sub Q Medication  Yes  No
- Injectable Medication  Yes  No
- Respirator/Trach  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)

<table>
<thead>
<tr>
<th>Medicare #: __________________________</th>
<th>Medicaid #: ________________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Total monthly income: $___________</th>
<th>from ○ SSI or SSD ○ Pension ○ other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Total monthly expenses: $___________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Savings account</th>
<th>Yes</th>
<th>No</th>
<th>If yes, current balance: $__________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>IRA, 401k, Investments</th>
<th>Yes</th>
<th>No</th>
<th>If yes, current balance: $__________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Stocks, Bonds</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Checking Account</th>
<th>Yes</th>
<th>No</th>
<th>If yes, current balance: $__________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you own: home/property?</th>
<th>Yes</th>
<th>No</th>
<th>If yes, estimated value: $__________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>1st mortgage balance: $___________</th>
<th>2nd mortgage balance if applicable $__________</th>
</tr>
</thead>
</table>

---

### ATTACHMENTS:
The following items MUST be attached to the application:

- Completed & Signed DNR Form
- Current Chest X-Ray (within 6 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: ___________________________________________

---

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: ________________________________

---

**ALL AREAS MUST BE COMPLETED**
REFERRAL INFORMATION FORM

A loving home for life’s last journey

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
COVID 19 _______ __________________________ 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: ______________________________

ALL AREAS MUST BE COMPLETED
**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:** ____________________________

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
○ Resistant
○ 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
### PATIENT NAME: ____________________

#### NURSING SUMMARY:

**Cardio-Pulmonary:**
- Temp: ___________  O  Ax  R  Secretions
- Pulse: ___________  AP  R  Quality  Describe: ____________________________
- BP: ___________  R  L  Tracheostomy  Size: ________ Type: ___________

**Oxygen Used/Breathing Treatment:** ______________________
- Rate: ___________________
- Method: ____________________________________

#### NUTRITION / HYDRATION:
- Height: _________  Diet:  Feeds Self  Dehydration
- Weight: _________  Total Feed  Edema
- Teeth: _________  Hyperalmentation  Vomiting
- No Teeth: _________  Feeding Tube Type  Dysphagia
- Dentures Type: _________  Date Inserted: _______________
- Denture with Patient: _________

#### SENSORY / COMFORT:
- VISION:
  - Adequate  A
  - Poor  D
  - Blind  U
  - Glasses  E
  - Contacts  I

- HEARING:
  - Adequate  A
  - Deaf  U
  - Aid  E
  - In Ear  I

- SPEECH:
  - Good  G
  - Difficult  D
  - Language: _______________________

- COMFORT:
  - Pain  Y
  - Where/When: _______________________

- SENSORY AIDS:
  - PT has them  Y
  - PT uses them  Y

#### PSYCHOSOCIAL:
- MENTAL STATUS:
  - Alert  A
  - Lethargic  L
  - Comatose  C
  - Oriented  O
  - Disoriented  D
  - Confused  C

- BEHAVIOR:
  - Wanders  W
  - Cooperative  C
  - Comative  A
  - Forgetful  F
  - Sleep Problems  S

- AFFECT:
  - Flat  F
  - Calm  C
  - Anxious  A

- SUPPORTS:
  - Lives with others  L
  - Lives alone  L
  - Gets help from others  G

#### ELIMINATION:

#### BLADDER:
- Continent  C
- Incontinent  I
- Retention  R
- Frequency  F
- Dribbling  D
- Last BM: ___________
- Type: ___________
- Appliance: ___________
- Toilet  T
- Bedpan  B
- Ostomy  O
- Catheter  C

#### BOWEL:
- Continent  C
- Incontinent  I
- Constipation  C
- Diarrhea  D
- Type: ___________
- Foley  F

#### SKIN:
- Skin Intact  Y
- Yes  Y
- No  N

Describe any impairments:
- Describe any impairments: ____________________________
- Size: ___________
- Site: ___________
- Drainage: ____________________________

#### HYGEINE / MOBILITY:
- Equipment / # Persons
- Oral Care: ___________
- Assist  A
- Total Dependent  D
- Total Dependence  T
- Independent  I

- Bathing: ___________
- Assist  A
- Total Dependent  D
- Total Dependence  T
- Independent  I

- Dressing: ___________
- Assist  A
- Total Dependent  D
- Total Dependence  T
- Independent  I

- Wheelchair: ___________
- Assist  A
- Total Dependent  D
- Total Dependence  T
- Independent  I

- Transfer: ___________
- Assist  A
- Total Dependent  D
- Total Dependence  T
- Independent  I

- Amputation: ___________
- Contractures  C
- Paralysis  P
- Paresis  A
- Other  O

#### SAFETY:
- Fainting  F
- Dizziness  D
- Headaches  H
- Seizures  S
- Weakness  W

Signature: ____________________________  Date: ____________________________

ALL AREAS MUST BE COMPLETED