



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 less than 6 months old
 Funeral arrangements made in advance.
 Negative COVID-19 test within 48 hours before entering Malachi House



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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:

Respirator/Trach	Yes	No	Sub Q Medication	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 Yes No If yes, current balance: \$ _____

Stocks, Bonds

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 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



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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
COVID 19 _____ _____ ATTACH A COPY TO THIS APPLICATION
(Negative COVID-19 test within 48 hours before entering Malachi House)

MRSA Yes No Site: _____

MEDICATION

Does patient refuse to take medications: Yes ____ **No** ____ **Sometimes** ____

Diet: _____ **Consistency:** _____

Referral Made By: _____ **Date:** _____



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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: _____

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: _____



MALACHI HOUSE

PATIENT NAME: _____

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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: Adequate Poor Blind Glasses Contacts
HEARING: Adequate Poor Deaf Aid In Ear _____
SPEECH: Good Difficult Unable Language: _____
COMFORT: Pain Yes No Where/When: _____
SENSORY AIDS: PT has them Yes No PT uses them Yes No

PSYCHOSOCIAL:

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

ELIMINATION:

BLADDER:
BOWEL: Continent Incontinent Retention Frequency Dribbling
TOILETING: Continent Incontinent Constipation Diarrhea Last BM: _____
 Independent Dependent Ostomy Type: _____ Appliance: _____
 Toilet Bedpan Catheter Foley Urostomy

SKIN:

Skin Intact Yes No
 Describe any impairments:
 Size: _____ Site: _____ Drainage: _____

HYGIENE / MOBILITY:

Used: _____ Equipment / # Persons _____
 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