## 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.
- Negative COVID-19 test within 48 hours before entering Malachi House
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  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  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:  ATTACH A COPY TO THIS APPLICATION
Chest X-Ray  _______  ________________
COVID 19  _______  ________________
(Negative COVID-19 test within 48 hours before entering Malachi House)

MRSA  ○ Yes  ○ No  Site: ___________________________________________________________________________

MEDICATION

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ______________________________________________________________**
RESIDENT PSYCHO-SOCIAL HISTORY

A loving home for life's last journey

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

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
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: _________  ○ Feeds Self  ○ Dehydration

Weight: _________  ○ Assist Feed  ○ Edema

○ Teeth  ○ Total Feed  ○ Nausea

○ No Teeth  ○ Hyperalmentation  ○ Vomiting

○ Dentures Type  ○ Feeding Tube Type  ○ Dysphagia

○ Denture with Patient  ○ Date Inserted: ________________________________

SENSORY / COMFORT:

VISION: ○ Adequate  ○ Poor  ○ Blind

Hearing: ○ Adequate  ○ Deaf  ○ Glasses

SPEECH: ○ Good  ○ Difficult  ○ In Ear

COMFORT: ○ Pain  ○ Yes  ○ No  ○ Language:

PT has them  ○ Yes  ○ No

PT uses them  ○ Yes  ○ No

SENSORY AIDS: __________________________________________________________________________

PSYCHOSOCIAL:

MENTAL STATUS: ○ Alert  ○ Lethargic  ○ Comatose  ○ Oriented  ○ Disoriented  ○ Confused

BEHAVIOR: ○ Wanders  ○ Cooperative  ○ Combative  ○ Forgetful  ○ Sleep Problems

AFFECT: ○ Flat  ○ Calm  ○ Anxious

SUPPORTS: ○ Lives with others  ○ Lives alone  ○ Gets help from others

ELIMINATION:

BLADDER:

Continent  ○ Continent

BOWEL:

Incontinent  ○ Incontinent

Retention  ○ Constipation

Frequency  ○ Diarrhea  ○ Type: ________________________________

Dribbling  ○ Last BM: ___________

Appliance: ___________

SKIN:

Skin Intact  ○ Yes  ○ No

Describe any impairments:

Size: ___________  ○ Yes  ○ No  ○ Drainage: ________________________________

HYGEINE / MOBILITY:

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