RICHARDSON GROUP SENIOR CITIZEN LIVING QUARTERS, INC.

Tel: ***215-743-5522*** *Fax:* ***215-743-4910*** ***A Nondiscriminatory Assisted Living***

We do not discriminate against any person's race, Color, religion, sex, national orientation, age, disability, sexual orientation, marital status, or any other class protected by federal, state, or local laws.

ADMISSION APPLICATION

Today's Date: _____

1. RESIDENT/CONSUMER INFORMATION

Applicant's Name: _____

Gender: Male: _____ Female: _____ Race: _____

DOB: _____ AGE: _____ SSN: _____ Date Housing Needed: _____

2. FINANCIAL INFORMATION

Source of Income & Amount

( ) SSDI $_____ ( ) SSI $_____ ( ) SS $_____

( ) VA $_____ ( ) PENSION $_____ ( ) OTHER $_____

If other, please specify income type: _____

Total Monthly Income: $_____ Total Cash on Hand: $_____

Name of Bank: _____

Checking Account? ( ) Yes ( ) No

Savings Account? ( ) Yes ( ) No

Direct Deposit? ( ) Yes ( ) No

Name(s) on Account? _____

Payee/Payer Name: _____

Relationship: _____

Address: _____

City/State/Zip:_____

Phone Number: (_____)_____ Ext: _____

FOR OFFICIAL USE ONLY

( ) Approved ( ) Denied ( ) Cancelled

3. REFERRAL SOURCE/CALLER INFORMATION

Person Completing Application: _____

Title: _____

Company Name (*If applicable*): _____

Address: _____

City/State/Zip: _____

Type of Company: _____

Phone Number: (_____)_____ Ext: _____

Alt./Cell/Beeper #: (_____)_____ Fax Number: (_____)_____

(Complete Below, If Applicant is Hospitalized/Rehabbing)

Institution Name: _____

Reason for Admission: _____

Date of Admission: _____ Discharge Date: _____

Contact Name: _____

Title: _____

Phone Number: (_____)_____ Ext: _____

Alt> Phone/Cell/Beeper#: _____

(Complete Below, If Applicant is Receiving MH/MR or Any Support Services)

Institution Name: _____

Contact Name: _____

Phone Number: (_____)_____ Ext: _____

Alt./Cell/Beeper #: (_____)_____ Fax Number: (_____)_____

Comment:_____

_____

4. DESIGNATED PERSON

Name: _____ Relationship: _____

Mailing Address: _____

Home Phone: (_____)_____ Work: (_____)_____

5. PREVIOUS HOME INFORMATION

Home Name (*if applicable*): _____

Full Address: _____

6. INSURANCE INFORMATION

Primary Insurance Name: _____

State ID # Group #: _____

Does applicant Have Insurance Card? ( ) Yes ( ) No

Secondary Insurance Name: _____

Number: _____

Does applicant Have Insurance Card? ( ) Yes ( ) No

NOTE: Applicant must have insurance to cover medication costs. Otherwise, all costs will be at applicant's expense.

7. PHYSICAL HEALTH INFORMATION

( ) Allergies (list below)
( ) Anemia
( ) Asthma
( ) Cancer
( ) Decubitus Ulcer
( ) Diabetes
( ) Epilepsy (Seizures)
( ) Gall Bladder Disease
( ) Weight Loss-significant
( ) Weight Gain-significant
( ) Other: _____
( ) None

( ) Infectious Disease
( ) Liver Disease
( ) Muscular Dystrophy
( ) Polio
( ) Rheumatic Fever
( ) Stroke
( ) Tuberculosis
( ) Venereal Disease
( ) Hay Fever
( ) Heart Trouble

( ) AIDES/HIV+
( ) Arthritis or Rheumatism
( ) Blood Disease
( ) Cerebral Palsy
( ) Diet Restrictions
( ) Emphysema
( ) Fainting Spells
( ) Gastrointestinal D/O
( ) Headaches
( )Diet Restrictions (list)
( ) Other: _____

( ) Kidney Disease
( ) Multiple Scierosis
( ) Parkinson's Disease
( ) Respiratory Disease
( ) Skin Problems
( ) Tobacco Use (smoker)
( ) Urinary Tract Disease
( ) Hepatitis
( ) High Blood Pressure

Allergies: _____

Diet Restrictions: _____

Diagnosis/History/Comment: _____

Medical Doctor's Name: _____

Company: _____

Address: _____ Phone: (_____)_____

8. PSYCHOLOGICAL/BEHAVIOR HEALTH INFO.

( ) Alcohol Abuse
( ) Mental Health
( ) Alzheimer's Disease
( ) Anxiety/Phobias/Panic Attacks/Excessive Fear
( ) Depression/Mood Swing/Bipolar/Mania
( ) Memory Loss/Confusion & Disorientation
( ) Poor Personal Hygiene
( ) Angry/Aggressive/Argumentative/Resists Supervision… handle stress
( ) Hallucination/Hearing Voices
( ) Trouble Concentrating/Organizing/Making Decisions
( ) Preoccupation With Physical Health
( ) Increase Body Movement/Pacing/Tremors/Twitches
( ) Slowed/Slurred Speech; Low/Monotonous Loss of Voice
( ) Low Self Esteem/Poor Motivation/Loss of Initiative
( ) Suicidal Threats – Ideations – Behaviors
( ) History of Violence and or Criminal Offense
( ) None

( ) Drug Abuse
( ) Mental Retardation
( ) Dementia
( ) Obsessive Compulsive Disorders
( ) Thought Disorders/Paranoid… Suspicious/Delusional
( ) Apathetic/Listless/Fearful/Dependent
( ) Overanxious/Worries A lot/Unable to handle stress
( ) Sleep Disturbance–Falling Asleep… Staying Awake
( ) Fatigue/Low Energy Level
( ) Eating Disorder/Appetite Loss/Appetite
( ) Poor Social Skills and Interactions
( ) Destructive to Property/Hx. Setting Fires
( ) Chain smoker… Unsafe smoker
( ) Exhibits Inappropriate Sexual Behavior
( ) Other: _____

Diagnosis/History/Comment: _____

Psychiatrist Name: _____

Therapist Name: _____-_____

Company: _____

Address: _____ Phone: (_____)_____

9. LIST OF CURRENT MEDICATION:

_____

_____

_____

_____

_____

10. EQUIPMENT USED

( ) Cane
( ) Catheter
( ) Colostomy
( ) Dentures
( ) Feeding Tube
( ) Glasses/Contact Lens
( ) Hearing Aid
( ) IM Injections
( ) Insulin Injection
( ) Oxygen Tank
( ) Oxygen Concentrator
( ) Prosthetic Device
( ) Respiratory Equipment
( ) Sterlie Dress
( ) Walker
( ) Other _____

11. LOSSES & IMPAIRMENT

( ) Amputated Limbs
( ) Hearing Loss
( ) Paralysis
( ) Poor Balance
( ) None
( ) Speech Impairment
( ) Unable To Read/Write
( ) Visual Impairment
( ) Other: _____

12. SPECIALIZED CARE REQUIRED

( ) Personal Care Reminders (ADLs)
( ) Respite Care; how long? _____
( ) 24 Hour Awake Supervision
( ) Special Diet
( ) Insulin Care
( ) Old Aged Adults (Seniors)
( ) None

NOTE: WE DO NOT PROVIDE THE FOLLOWING CARE:

Catheter Care	Nasa-gastric Feedings	Colostomy Care
Non-self Care Inhaler	Tracheotomy Care	Oxygen Monitoring
Special Skin Care	Incontinent of Bladder	Decubiti Care
Incontinent of Bowel	Wandering Adult	Intravenous Fluids

13. <u>SPECIFIC PERSONAL CARE NEEDS</u>

( ) Securing Transportation
( ) Shopping
( ) Making/Keeping Appointments
( ) Care Of Personal Possessions
( ) Eating
( ) Dressing
( ) Correspondence
( ) Social & Leisure Activities
( ) Shaving
( ) Ambulation
( ) Financial Management
( ) Use Of Phone
( ) Haircuts
( ) Hair Grooming/Shampooing
( ) Use Of Prosthetic Devices
( ) Bathing
( ) Toilet Habits
( ) Oral Hygiene
( ) Securing Healthcare
( ) Nail Care
( ) Medication Management
( ) None

History Comment: _____

_____

14. ADMISSION REQUIREMENTS:

- Proof of Income (*award letter, copy of check, or income statement*).
- Medical Insurance & Card (*If not insured, medication cost will be at applicant's expense*).
- PCBH Assessment Summary, if applicable.
- MA-51 & Recent Medical Reports.
- $100.00 Admission Fee (non-refundable)
- First Month's Rent

NOTE: APPLICATION MUST BE COMPLETED AND FAX BACK TO RICHARDSON GROUP, SCLQ, INC. FAX#: 215-743-4910.

APPLICANT WILL BE CONSIDERED FOR ADMISSION AFTER APPLICATION IS REVIEWED