Country Comfort

Alternative Living

10546 River Road, New Columbia, PA 17856
Phone: 570-568-1090 Fax: 570-568-1095

CRITERIA FOR ADMISSION

We will admit any person, upon assessment by our Administrator, whose needs can be met by Country Comfort Alternative Living, provided the client requires assistance with the activities listed below and desires to live in our community. Potential residents must be able to meet their economic responsibilities.

Assisted Activities:

Meals
Bladder Management
Personal Hygiene
- Bathing
- Grooming
- Dressing/undressing

Securing Healthcare
Managing Healthcare
Personal Laundry
Shopping
Securing and using Transportation
Using the telephone
Making and keeping appointments
Caring for personal possessions
Writing correspondence
Engaging in social and leisure activities
Obtaining clean, seasonal clothing

Country Comfort will not accept persons who are or have the following, since we cannot meet their needs or provide the necessary services:

Wheelchair bound
Alcohol abusers
Narcotic abusers
Megan Law Offenders
Convicted Criminal record for:
- Assault
- Rape
- Murder
- Arson
- Theft

Catheter
Colostomy
Alzheimer's Clients who:
- Wander
- Refuse assistance
- Are bowel Incontinence
- Are combative or aggressive
- Are incapable of feeding themselves

Country Comfort reserves the right to refuse admittance of a client if we feel we cannot meet their needs and/or they are a risk to the safety and well-being of the current clients.

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APPLICATION FOR ADMISSION

Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin, age, or sex.

Date of Application: ____________________ Male ☐ Female ☐

1. Name of Applicant: ____
Last First Middle

2. Address: ____
Number Street City State Zip Code

Telephone: ______________ ______________ ______________
(Daytime) (Evening) (Cell)

3. Age: ______ Birthdate: ______________ Birthplace: ____________________

4. Previous Occupation: ____

Veteran: ☐ Yes ☐ No Veteran's Widow: ☐ Yes ☐ No

5. Marital Status:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

____
Name of Spouse If Deceased, Date of Death

____
Address of Spouse (If Living) Phone

Is spouse currently employed? ☐ Yes ☐ No

____
Address of Employer Phone

6. List Children, Nearest Relative or Responsible Persons
(In the order to be notified in case of emergency)

Name Address Phone

____

____

____

____

7. Do you have a Power of Attorney (POA)? (Please provide a copy) ☐ Yes ☐ No

Do you have a legal guardian? ☐ Yes ☐ No

Do you have an advance directive (also known as a living will)? ☐ Yes ☐ No

(Please provide a copy)

Name of Attorney-In-Fact designated in POA or Guardian Relationship

____

Name Address Phone

8. Religious Affiliation

____ ☐ ☐

Pastor's Name Member Non-member

____

Church Name and Address Phone

9. Family Physician

____

Physician Name Address Phone

10. Hospital Preference

____

11. Funeral Director

____

Name

____

Address Phone

12. Social Security Number: ______________________________

____
Medicare Number

____
Insurance ID Number   Insurance Plan Number   Insurance Group Number

65 Special Yes ☐ No ☐ Security 65 Yes ☐ No ☐ Blue Shield? Yes ☐ No ☐

Please provide a copy of all insurance cards at time of admission.

Other Hospitalization, Health Care or Nursing Home Insurance

Company Name   Address   Contract/Agreement Number

____

____

____

____

13. Current Medical Conditions

____

____

____

____

14. Current Medications

____

____

____

____

____

____

____

____

15. Former Hospitalization

Name of Hospital Date

Name of Hospital Date

Name of Hospital Date

16. Former Nursing Home Stay

Name of Nursing Home Date

Name of Nursing Home Date

Name of Nursing Home Date

17. Have you ever been convicted of a misdemeanor, felony, and/or abuse of children or adults? Yes ☐ No ☐

If yes, please explain below:

18. Resident Profile

<table>
<tr><td colspan="12">Name</td></tr>
<tr><td colspan="3">Ethnic/Culture Background</td><td colspan="3">Languages</td><td colspan="3">Education</td><td colspan="3">Occupation</td></tr>
<tr><td colspan="2">Work History
1.</td><td>From</td><td>To</td><td colspan="4">3</td><td colspan="2">From</td><td colspan="2">To</td></tr>
<tr><td colspan="2">2.</td><td></td><td></td><td colspan="4">4</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="4">Number of Children
☐ Living ☐ Deceased</td><td colspan="4">Number of Grandchildren
☐ Living ☐ Deceased</td><td colspan="4">Number of Siblings
☐ Living ☐ Deceased</td></tr>
<tr><td colspan="6">List recent losses (i.e. death of spouse,, family member, etc.)
1</td><td colspan="6">3</td></tr>
<tr><td colspan="6">2</td><td colspan="6">4</td></tr>
<tr><td colspan="12">Living Situation prior to placement:</td></tr>
<tr><td colspan="12">Reason for Placement:</td></tr>
<tr><td colspan="12">Social Participation</td></tr>
<tr><td colspan="3">Organization Membership</td><td colspan="4">Volunteer Work</td><td colspan="3">Registered Voter
☐ Yes ☐ No</td><td colspan="2">Wish to Vote
☐ Yes ☐ No</td></tr>
<tr><td colspan="3">Religion</td><td colspan="9">Spiritual Activities</td></tr>
<tr><td colspan="12">Recreation Interests/hobbies</td></tr>
<tr><td colspan="12">Service Supports – List agencies that will provide services to client</td></tr>
<tr><td colspan="4">Agency</td><td colspan="5">Contact Person</td><td colspan="3">Phone</td></tr>
<tr><td colspan="4"></td><td colspan="5"></td><td colspan="3"></td></tr>
<tr><td colspan="4"></td><td colspan="5"></td><td colspan="3"></td></tr>
<tr><td colspan="4"></td><td colspan="5"></td><td colspan="3"></td></tr>
<tr><td colspan="12">DOES THE CLIENT REQUIRE THE USE OF ANY OF THE FOLLOWING?</td></tr>
<tr><td colspan="12">Place an (X) for any item required and a (XX) if client requires assistance</td></tr>
<tr><td colspan="4">☐ Glasses or Contact Lenses</td><td colspan="4">☐ Pacemaker</td><td colspan="4">☐ Cane</td></tr>
<tr><td colspan="4">☐ Dentures</td><td colspan="4">☐ Respiratory Equipment</td><td colspan="4">☐ Wheelchair</td></tr>
<tr><td colspan="4">☐ Hearing Aid</td><td colspan="4">☐ Portable Oxygen</td><td colspan="4">☐ Walker</td></tr>
<tr><td colspan="4">☐ Prosthetic Devices</td><td colspan="4">☐ Other Medical Equipment</td><td colspan="4">☐ Other</td></tr>
</table>

Name:

Indicate with an (X) each factor that applies:.

HEALTH PROFILE				Mental Functioning and Challenging Behaviors	
	Alcohol/Drug Abuse		Mental Retardation		Anxiety, phobia panic attacks, excessive fear
	Alzheimer's/Dementia		Multiple Sclerosis		Obsessive – compulsive disorders
	Anemia		Muscular Dystrophy		Mood swing, bipolar, depression, mania
	Arthritis or Rheumatism		Parkinson's Disease		Thought disorders, paranoid, suspicious, delusional
	Asthma		Polio		Memory loss, confusion, and disorientation
	Blood Disorders		Respiratory Disease		Apathetic, listless, fearful, dependent
	Cancer		Rheumatic Fever		Poor personal hygiene
	Cerebral Palsy		Skin Problems		Overanxious, worries a lot, unable to handle stress
	Decubitis ulcers		Stroke		Angry, aggressive, argumentative, resists supervision
	Diabetes		Tobacco Use		Hallucination. Hearing voices
	Emphysema		Tuberculosis		Sleep disturbance, difficulty falling asleep, staying awake
	Epilepsy (seizures)		Urinary Tract Disease		Trouble concentrating, organizing, making decisions
	Fainting Spells		Venereal Disease		Fatigue, low energy level
	Gall Bladder Disease		Weight Loss – Significant		Preoccupation with physical health
	Gastrointestinal Disorders		Weight Gain – Significant		Eating disorder, loss of appetite or increased appetite
	Hay Fever		Other – (specify below)		Increased body movements, pacing\tremors, twitches
	Headaches	**Losses & Impairments**			Poor social skills and interactions
	Heart Trouble		Speech Impairments		Slowed or slurred speech, low or monotonous tone of voice
	Hepatitis		Paralysis		Low self-esteem, poor motivation, loss of initiative
	High Blood Pressure		Visual Impairments		Destructive to property, history of setting fires, unsafe smoking
	Infectious Disease		Amputated Limbs		Chain smoker
	Kidney Disease		Hearing Loss		Suicidal threats or behaviors
	Liver Disease		Poor Balance		Exhibits inappropriate sexual behavior
	Mental Illness		Unable to read/write		History of violence and/or criminal offense

Relevant Details:

I hereby certify that the supplied information is correct and complete to the best of my knowledge. I understand that any misrepresentation could result in the forfeiture of my status as a resident of the facility, that this application does not obligate the facility in any way, and that the information given herein is strictly confidential.

19. Signature of Applicant

____

Signature of Applicant Date

20. Please Complete This Section If Prepared By Other Than The Applicant.

____

Name Date

____

Relationship

____

Address Phone

This area to be used by Administration only

Date of Admission: ____________________

Special Administrative Notes:

____

____

____

____

____

____

Date of Discharge: ______________________

Discharge to: ____

Reason: ____

____

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<u>What Furniture Should I Bring:</u>

- Single Bed (if available)
- One of more chairs (depends on size)
- Dresser and/or chest of drawers
- Small bedside table or stand
- Lamp for bedside table
- Lamps for visibility in room
- TV with stand (optional)
- Any other tables that would fit in room
- Pictures
- Clock
- Phone (optional)

<u>What Other Items Will I Need:</u>

- 3 sets of bed linens
- Bed pillow(s)
- Blanket and Bed Spread or Comforter
- A minimum of 3 sets of bath linens (bath towel, hand towel, and washcloth)
- One waste can for room (waste can for bathroom will be furnished)
- A minimum of 7 days of clothing, robe, and slippers
- Laundry basket or hamper
- Clothes hangers
- Hygiene items
- Flashlight

<u>What Items Do I Need to Complete Admission:</u>

- MA 51 Medical Evaluation and/or DME medical evaluation Form completed by your physician
- Relatives names, addresses, and phone numbers
- List of medications
- Insurance information and cards
- Medical information (such as diet needs, sugar checks, blood pressure checks, history information, etc.)
- All doctors' names, addresses, phone numbers
- Living Will Declaration
- Do Not Resuscitate Order (if appropriate)
- Pharmacy preference (if appropriate)