IDENTIFICATION AND EMERGENCY INFORMATION

This information is required under the H & S Code and the regulations of the Department to be maintained on every person admitted to a community care facility, to be readily available to the person in charge, but not accessible to unauthorized persons. All information must be kept current. See other side for additional information required for residential facilities for children.

A. ALL FACILITIES [EXCEPT CHILD CARE CENTER/FAMILY CHILD CARE HOME COMPLETES LIC 700]

1. NAME OF CLIENT OR CHILD | SOCIAL SECURITY NUMBER (OPTIONAL) | DATE OF BIRTH | AGE | SEX
2. RESPONSIBLE PERSON OR PLACEMENT AGENCY | ADDRESS | TELEPHONE ( )
3. NAME OF NEAREST RELATIVE (OPTIONAL) | RELATIONSHIP | ADDRESS | TELEPHONE ( )
4. DATE ADMITTED TO FACILITY | ADDRESS PRIOR TO ADMISSION
5. DATE LEFT | FORWARDING ADDRESS
6. REASONS FOR LEAVING FACILITY

7. PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, IF ANY

NAME	ADDRESS	TELEPHONE
		( )
		( )
		( )

8. OTHER PERSONS TO BE NOTIFIED IN EMERGENCY

NAME	ADDRESS	TELEPHONE
a. PHYSICIAN		( )
b. MENTAL HEALTH PROVIDER, IF ANY		( )
c. DENTIST		( )
d. RELATIVE(S)		( )
e. FRIEND(S)		( )
		( )

9. EMERGENCY HOSPITALIZATION PLAN

NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY | ADDRESS OF HOSPITAL TO BE TAKEN IN AN EMERGENCY

MEDICAL PLAN | MEDICAL PLAN IDENTIFICATION NUMBER

NAME OF DENTAL PLAN (IF ANY) | DENTAL PLAN NUMBER (IF ANY)

10. OTHER REQUIRED INFORMATION

a. AMBULATORY STATUS

b. RELIGIOUS PREFERENCE | NAME AND ADDRESS OF CLERGYMAN OR RELIGIOUS ADVISOR, IF ANY | TELEPHONE ( )

11. COMMENTS

SIGNATURE OF RESIDENT | SIGNATURE OF PERSON COMPLETING FORM | TITLE | DATE

PREPLACEMENT APPRAISAL INFORMATION

Admission - Residential Care Facilities

NOTE: *This information may be obtained from the applicant, or his/her authorized representative. (Relatives, social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).*

APPLICANT'S NAME | AGE

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))

HEALTH HISTORY (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS

OUT OF BED ALL DAY

IN BED ALL OR MOST OF THE TIME

IN BED PART OF THE TIME

COMMENT:

TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY?

YES NO

DATE OF TB TEST

POSITIVE

NEGATIVE

ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS?

YES NO

ACTION TAKEN (IF POSITIVE)

GIVE DETAILS

AMBULATORY STATUS (this person is ambulatory nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

YES	NO	
		Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
		Mentally and physically able to follow signals and instructions for evacuation.
		Able to use evacuation routes including stairs if necessary.
		Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

YES	NO			
		Active, requires no personal help of any kind - able to go up and down stairs easily		
		Active, but has difficulty climbing or descending stairs		
		Uses brace or crutch		
		Feeble or slow		
		Uses walker. If Yes, can get in and out unassisted?	Yes	No
		Uses wheelchair. If Yes, can get in and out unassisted?	Yes	No
		Requires grab bars in bathroom		
		Other: (Describe)		

SERVICES NEEDED (Check items and explain)

YES	NO	
		Help in transferring in and out of bed and dressing
		Help with bathing, hair care, personal hygiene
		Does client desire and is client capable of doing own personal laundry and other household tasks (specify)
		Help with moving about the facility
		Help with eating (need for adaptive devices or assistance from another person)
		Special diet/observation of food intake
		Toileting, including assistance equipment, or assistance of another person
		Continence, bowel or bladder control. Are assistive devices such as a catheter required?
		Help with medication
		Needs special observation/night supervision (due to confusion, forgetfulness, wandering)
		Help in managing own cash resources
		Help in participating in activity programs
		Special medical attention
		Assistance in incidental health and medical care
		Other "Services Needed" not identified above

Is there any additional information which would assist the facility in determining applicant's suitability for admission? Yes No

If Yes, please attach comments on separate sheet.

To the best of my knowledge; I (the above person) do not need skilled nursing care.

SIGNATURE	DATE COMPLETED
APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE	
SIGNATURE	DATE COMPLETED
LICENSEE OR DESIGNATED REPRESENTATIVE	DATE COMPLETED