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 C	ARE CENTER/FAMILY CHILI	D CARE HO	ME COMPLETE	S 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 A	DMISSION		()	
5. DATE LEFT	FORWARDING ADDRES	s	· · · · · · · · · · · · · · · · · · ·		
6. REASONS FOR LEAVING FACILITY					
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NAME	E FOR FINANCIAL AFFA	IRS, PAYMENT FOR CARE, I ADDRESS	LEGAL GUA		
INAME	İ	ADDRESS	· · · · · · · · · · · · · · · · · · ·	TELEPHONE	-
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			()		
8.	OTHER PERSONS TO BE	NOTIFIED IN EMERGENCY			
NAME a. PHYSICIAN		ADDRESS	·	TELEPHONE	
d. Phisician			()		
b. MENTAL HEALTH PROVIDER, IF ANY			ļ , ,		
c. DENTIST			()		
d. RELATIVE(S)			()		
			()		
o. FRIEND(S)				· • ·	
9.	EMERGENCY HOS	SPITALIZATION PLAN			
NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY		ADDRESS OF HOSPITAL TO BE TAKEN IN A	N EMERGENCY		
MEDICAL PLAN		MEDICAL PLAN IDENTIFICATION NUMBER	· · · · · · · · · · · · · · · · · ·		
NAME OF DENTAL PLAN (IF ANY)		DENTAL PLAN NUMBER (IF ANY)			
10.	OTUED DEGUE				
a. AMBULATORY STATUS	OTHER REQUIR	ED INFORMATION			
b. RELIGIOUS PREFERENCE NAME AND	D ADDRESS OF CLERGYMAN OR RELIGIO	DUS ADVISOR, IF ANY		TELEPHONE	
11. COMMENTS	· · · · · <u> · · · · · · · · · · ·</u>		·	()	
SIGNATURE OF RESIDENT SIGNATUR	RE OF PERSON COMPLETING FORM	TITLE	· · · · · 	DATE	
LIC 601 (8/08) Personal		er til til det			Page 1 of 2

PREPLACEMENT APPRAISAL INFORMATION

Admission - Residential Care Facilities

YES NO ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS? YES NO GIVE DETAILS POSITIVE NEGATIVE ACTION TAKEN (IF POSITIVE)	physician may assist the applicant in completing this form		
PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech) MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: perticipation in social activities (i.e., active or withdrawn)) MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: perticipation 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 RED. ALL DAY IN SID ALL DAY OF THE TIME INSID ALL OR MORE OF THE TI	APPLICANT'S NAME	na de la composition br>La composition de la	AGE
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	LIC 603 (9/99)	(Over)	The second secon

AMRIIIA	TOPV	TATUS (this person is ambulatory nonambulatory)						
		TATUS (this person is ambulatory nonambulatory) s able to demonstrate the mental and physical ability to leave a build	ing without the assistance	of a person or the use of a mechanical device				
An ambul	atory pe	rson must be able to do the following:	g minout the addiction	. 5. 5 person of the tide of a mountained device.				
		Able to walk without any physical assistance (e.g., walker, crutche		o 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).							
FUNCTIO	NAL CA	APABILITIES (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)						
SERVICE	S NEED	ED (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 laur	ndry 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						
		Moodo angial abaggatian/sight angagisia (day)						
		Needs special observation/night supervision (due to confusion, forgetfulness, wandering)						
		Help in managing own cash resources						
			**					
		Special medical attention		****				
		Assistance in incidental health and medical care						
		Other "Services Needed" not identified above						
Is there a	nv additie	onal information which would assist the facility in determining applica	ent's suitability for admissi	on? Yes No				
		ch comments on separate sheet.	int 5 Suitability for admission	on: Tes No				
			300					
SIGNATURE		and and a state persons to not need skilled harding of	116.	DATE COMPLETED				
ADDI ICANT A	CHENT CO	AUTHORIZED REPRESENTATIVE						
AFFLIVANI (CLIENT) OR							
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