Please answer the following questions related to the Consumer:

FIRST NAME: _____ **MIDDLE:** _____ **LAST:**_____

DATE OF BIRTH: _____ **SSN:**_____ **GENDER:**_____

RACE:_____ **MARITAL STATUS:**_____ **CLIENT REF#:** _____

VETERAN STATUS: _____ **IS THERE A SURVIVING SPOUSE/ CHILD OF VETERAN:** _____

PRIMARY LANGUAGE:_____

FUNERAL PROVISIONS, if applicable:_____

COURT ORDER?_____ **IF SO, TYPE:**_____ **EXPIRES:**_____

COUNTY WHICH ORDER WAS ISSUED?:_____

FUNERAL PROVISIONS AND PREFERENCES:_____

RELIGIOUS PREFERENCE:_____

CURRENT RESIDENCE/ADDRESS/PHONE: _____

_____

REFERRAL SOURCE CONTACT:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____

PHYSICIAN:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone#:_____ Fax#:_____

Email:_____

PSYCHIATRIST:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

RESPONSIBLE AGENCY:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

CASE MANAGER:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____

EMERGENCY CONTACT:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____ Relationship: _____

NEXT OF KIN:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____ Relationship: _____

GUARDIAN:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____ Relationship: _____

PAYEE/CONSERVATOR:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

Email: _____ Relationship: _____

DIAGNOSIS:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

DIET: _____ **ALLERGIES:** _____

CONTRACTED SERVICES:

- ☐ **Case Management**
- ☐ **Psychiatric Services**
- ☐ **Individual Counseling**
- ☐ **Dialectical Behavior Therapy**
- ☐ **Behavior Treatment Plan**
- ☐ **Group Counseling**
- ☐ **Enhanced Staffing**

If Enhanced Staffing,
Explain:_____

ADVANCED DIRECTIVES:

Does Individual have an Advanced Directive? YES or NO If Yes, attach a copy.

Is there a Psychiatric Advance Directive? YES or NO If Yes, attach a copy

Does the Individual currently have Medicaid and/or Social Security Benefits? Y or N
(*if the Individual does have Benefits, please include Policy Number & Types of Policies*)

Will Beacon Staff need to assist Individual in applying for Benefits? Y or N

☐ **Medicaid:** **Medicaid Number/Plan:**_____

Spend down? Y or N **If yes, amount?**_____

☐ **Medicare:**

- ☐ **Part A** _____
- ☐ **Part B**_____
- ☐ **Part C**_____
- ☐ **Part D**_____
- ☐ **Medicare Advantage Plan:**_____

☐ **Private Insurance** (*name of plan and ID number*):_____

Does this Individual have current insurance cards (*not copies*)**? Y or N**

If no, can physical cards be requested? Y or N

Does Individual receive SSI (Supplemental Security Income)? Y or N

If so, how much do they receive a month?:_____

Does this individual have a valid state ID? Y or N

Is the Individual a Diabetic? Y N

If Yes, does the Individual have a Guardian? Y N

Any Medication Compliance Issues? Y N

Explain:_____

Does this Individual require any skin or wound care/ treatments? Y N

Is the Individual a Suicide Risk? Y N

Is the Individual a Threat or Danger to others? Y N

Does the Individual have Thoughts of Harm to others? Y N

Has the Individual had any recent Threatening Behaviors? Y N

Has the Individual had an overall change/ decline in cognitive functioning? Y N

If yes, is this change expected to improve? Y N

Does the Individual have difficulty with short term recall/ memory? Y N

Does the Individual have a diagnosis/ symptoms of Dementia NOS, Alzheimer's, Lewy Body, Vascular Dementia, or other type of Dementia? Y N

If yes, please list diagnosis/ symptoms. _____

_____

Is there any presence of other High Risk Behaviors? (ie: cutting, head hanging, elopement, self injurious behavior, poor or dangerous relationships, risk taking, etc...) Y N

_____

Does this Individual appear to be compatible with other individuals in the home?
Are there any foreseeable problems? **Y N**

_____

Does this Individual require continuous nursing care? Y N

_____

Does this Individual require isolation for medial purposes? Y N

Does this Individual require seclusion or restraint? Y N

Does this Individual currently present an immediate danger to themselves or others?

Is this an Individual who requires shelter only? Y N

What amount of Personal Care does this Individual need? *Write in the amount of Personal Care the Referral Source indicates the Individual needs.*

What amount of Supervision does this Individual need? *Examples of this would include supervision when in the community, line of sight, one on one*

What amount of Protection does this Individual need? *Include whether the Individual has a high potential of being a victim of abuse.*

What kind of Skills does the home need to have available to meet this Individuals needs?
Examples: nurse, social worker, therapist, gentle teaching, etc...

What kind of Physical Accommodations does the home need to have to be able to meet this Individuals needs? *Examples: alarms, fence, staffing levels, handicap accessibility, etc...*

PLEASE ATTACH THE FOLLOWING REQUIRED DOCUMENTS IF AVAILABLE:
Guardianship Paperwork
Health Care Appraisal
Current Psychiatric Evaluation
Any Psychological Assessments, etc.
Current Prescriptions
Clinical Certifications
Treatment Orders
Current Medication List, if applicable
Current Person Centered Plan
Behavior Plan, if applicable

<u>Note:</u> (If Individual is to be placed behind a fence, a Behavior Plan is required upon Admission)

Community Access

Will this individual have independent community access at the time of intake?

Y or N

If yes, how many hours per day/ per week will this individual be able to access the community independently?

Beacon Specialized Living Services, Inc. community access guidelines:

The Resident must sign in and sign out with facility staff upon leaving and returning from community access.

The Organization is not responsible for transportation to, or from community access.

The resident is responsible for being present for all medication passes.

Resident to staff ratio will be maintained and elopement policies will be followed identically to facility policies unless otherwise indicated in the individual's plan.

Staff will maintain routine checks during supervised community outings, unless stated otherwise in individual's plan.

RESIDENT ADMISSION CHECKLIST

Please ensure the following items are accounted for at time of pick-up.

Resident Name: _____ Weight_____ Height_____

☐ Photo ID
☐ Insurance Cards and/ or Copy of Insurance Cards

Medications:
☐ Copy of Prescriptions ☐ Epi-Pen (if applicable)
☐ Attach Medication List
Name of Pharmacy where Prescriptions were filled

_____

Medical Equipment:
☐ C-Pap or Bi-Pap

If Diabetic:
☐ Glucometer ☐ Test Strips ☐ Lancets
☐ Needles/ Syringes
Who supplies this equipment? (Local Pharmacy, Binsons, Healthy Living, etc.)

_____

If on Oxygen:
☐ Concentrator ☐ Back-up Tank ☐ Tubing
☐ Mask and/ or Nasal Cannula

If has Nebulizer:
☐ Nebulizer ☐ Tubing ☐ Mask
☐ Medication for Nebulizer

Assistive Devices:
☐ Walker ☐ Cane ☐ Wheelchair
☐ Crutches ☐ Shower Chair ☐ Eye Glasses
☐ Dentures ☐ Incontinence Supplies (Adult Diapers, etc.)
☐ Gait Belt

Who is the supplier of the incontinence products?_____

Has individual been using a hospital bed? ☐ Yes ☐ No

Does this individual use a hoyer, and if so do they have one of their own?
☐ Yes ☐ No

☐ Other Equipment/ Medical Supplies:_____

_____

Are there Prescriptions/ Order to use these supplies? ☐ Yes ☐ No

Case Manager Signature: _____ Date: _____