Admission Application

Please complete in ink.

Residential Care ☐
Respite Care ☐
Day Program ☐

Date of Application _____

Applicant's Name _____
Last *First* *Middle*

Address _____

City _____ State _____ Zip _____

Phone _____ Birthdate _____ Age _____ Sex _____ Race _____

Social Security Number _____ Medicare Number _____

Private Insurance Company Name and Phone **(Not Needed for Day Program)** _____
Insurance Policy Number _____

Religious Affiliation _____ Clergyman/Rabbi _____
Telephone Number _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Does applicant have an Out-Of Hospital DNR? Yes (please attach) ☐ No ☐

Directives to Physicians for End of Life ☐ Heroic Measures (aka Full Code) ☐ Allow Natural Death (aka DNR)

Organ(s) Donation _____

If you do not have DNR/Allow Natural Death or other Advanced Directive documents completed, our social worker and attending physicians will provide you with sample forms, and can assist you in completing the documents according to your preferences.

Durable Power of Attorney/Guardian Name _____

Relationship to Applicant _____

Address _____ City _____ State _____ Zip _____

Residence Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____

Emergency Contact 2 _____ Relationship to Applicant _____
Address _____ City _____ State _____ Zip _____
Residence Phone _____ Work Phone _____ Cell Phone _____
Email Address: _____

Emergency Contact 3 _____ Relationship to Applicant _____
Address _____ City _____ State _____ Zip _____
Residence Phone _____ Work Phone _____ Cell Phone _____
Email Address: _____

Does the applicant presently reside in another care center? _____

Date of admission _____ Facility Name _____

Have you ever been denied residence or been asked to move from, another care center? If so, state reason. ____

The following information is requested to assist the staff in developing an appropriate care plan to meet the individual, personal needs of the resident.

PERSONAL DATA

Applicant's trade or profession prior to retirement _____

Employer _____

Date of last employment _____

Family Member most dependent on _____

Relationship _____

HEALTH DATA

Applicant's Regular Physician _____ Phone _____

Address _____

City _____ State _____ Zip _____

When did applicant last consult a physician or attend a clinic/hospital? _____

Other physicians seen within the past five years

1. Name, Specialty and Phone _____
2. Name, Specialty and Phone _____
3. Name, Specialty and Phone _____
4. Name, Specialty and Phone _____

(Residents Only) Will your regular physician supervise care at West Center? Yes ☐ No ☐

(Residents Only) If no, please select a West Center Physician: Janice Knebl, DO ☐ Sarah Ross, DO ☐

Recent Medical Issues and/or Hospitalizations _____

Principal Diagnoses

Medications (include non-prescription drugs taken on a regular basis) _____

Does the applicant use tobacco?_____

WEST CENTER ADMISSION APPLICATION Resident Name: _____

Pharmacy _____ Phone _____

Food, Drug or Environmental Allergies

Are any of the above allergies severe and/or life-threatening? If so, which ones? _____

Applicant's Dentist _____ Phone _____

Address _____

City _____ State _____ Zip _____

When did applicant last consult a dentist? _____

Would applicant like to use the in-house dentist? _____

Dietary:

Height _____ Weight _____ Usual Adult Weight _____

Diet Restrictions _____ Texture Modified _____

Appetite: ☐ Good ☐ Fair ☐ Poor

Food likes/dislikes

_____

Preferred breakfast foods and time: _____

Preferred beverages _____

Alcohol use per week _____

Any problems with chewing and swallowing? _____

Problems using utensils? _____

Requires one on one assistance/ feeding _____

Does the applicant use liquid nutritional supplements? _____

Please list any other comments related to diet and food intake: _____

Personal Care:

Bathing: ☐ Self ☐ Needs assistance ☐ Resists bathing

Prefers: ☐ Bed ☐ Tub ☐ Shower ☐ Sink/Washcloth

☐ Morning ☐ Evening ☐ Every Day ☐ 2-3 times per week ☐ Shampoos ☐ Self ☐Beauty Shop

☐ Sensitivity to soap or lotion ☐ Dry Skin ☐ Frequent odor

☐ Shaves with ☐Electric Razor☐Razor

Skin: ☐ Intact ☐ Pressure Ulcer ☐ Special Care _____

Toileting: ☐ Takes Self to Bathroom/No Accidents

☐ Mostly Continent with Occasional accidents

☐ Requires cueing and/or physical assistance

Incontinent of ☐ Bladder ☐ Bowel ☐ Uses Disposable Briefs or Pads

Sleeping Habits: Usual time to go to bed: _____ Usual waking time: _____

Naps during the day for _____ (length) at _____ (time)

Up at night _____

Mobility/Ambulation: ☐ Independent ☐ Needs Assistance
☐ Immobile unless assisted ☐ Wheelchair ☐ Walker/Cane
☐ Unsteady/Dizziness ☐ Has fallen within past 6 months ☐ Yes ☐ No Injury?_____
☐ Requires assistance with transfers ☐One Person ☐Two People ☐Hoyer Lift
Usual Footwear _____

Dental Hygiene:
☐ Self ☐ Needs Assistance

Grooming and Hair Care: ☐ Self ☐ Needs Assistance ☐ Beauty Shop/Barber _____times per month

Hearing Impairment: ☐ Right ☐ Left
Hearing Aid: ☐ Right ☐ Left Do you have hearing aid replacement insurance? _____

Dentures: ☐ Full ☐ Partial
☐ Upper ☐ Lower

Eye glasses: _____ Vision prescription (if known) _____

Any other significant physical history (Include care issues, surgery, and hospitalizations not mentioned above)

EMOTIONAL AND MENTAL STATUS

Has the applicant's cognitive and mental condition been tested? (If so, please provide date, tester's contact information, and/or copy of the results) Yes ☐ Never been tested ☐

Temperament and personality

_____

Recent Changes in Behavior

_____

When Changed _____

Condition over past three months: Stable ☐ Slow Decline ☐ Dramatic Change ☐

Problems *during the past three months*:

Memory Impairment—mild ☐ severe ☐

Belligerence ☐ Physical aggression with care ☐ Verbal aggression with care ☐

Unprovoked verbal or physical aggression ☐ Demanding ☐

Unusually Poor Hygiene ☐ Wandering ☐ Fearful ☐

Borrows or hoards items ☐ Hallucinations ☐

Verbal outbursts (please describe) ☐ _____

Sexually inappropriate behavior (please describe) _____

Other behavior that is dangerous to self or others (please describe) _____

Short Attention Span ☐ Restless ☐ Depressed Mood or withdrawal ☐

Can Accurately Relate: Time _____ Place _____

Can identify Self _____ Can Identify Close Relatives/Friends _____

Communication Skills

_____

Has applicant been known to wander off from home or leave a secure area either at home or in a facility unattended? If so, where did applicant go and how did you prevent the situation from reoccurring?

OTHER IMPORTANT DATA

(Residential & Respite Care Only)

Type of Room Preference: ☐ Private ☐ Semi Private

Will applicant want a private room when available? _____

Funeral Home:

Funeral Arrangements Have Been Made at _____

Funeral Director _____ Phone _____

Address (city, state, zip) _____

Hospital of Choice:

Hospital of Choice (Name & Address)

TRANSPORTATION INFORMATION (*West Center Day Program* Only)

☐ Private Vehicle/ Family:

Contact Name _____ Phone _____

☐ Commercial Transportation:

Agency Name _____ Phone _____

The information I have provided in this application is current and correct to the best of my knowledge.

Signature: _____ Date _____

Relationship to Applicant _____

Life Enrichment & Recreation Form

We would greatly appreciate if you could take a few minutes to give us this additional information on your loved one. Thank you!

Name: _____ Prefer to be called: _____

I was born in: _____ I was raised in: _____
I consider _____ to be my home.

Veteran of the Armed Forces? ☐ Yes ☐ No

Branch _____ Rank _____ Years of Service: _____
Medals: _____

Activity Interests:

- Please check in the box "P" if past interest, "C" for current interest, and "N" for never interested

Activity	P	C	N	Activity	P	C	N
Going out and about	☐	☐	☐	Music/Singing	☐	☐	☐
Trips/Shopping	☐	☐	☐	Helping others	☐	☐	☐
Special Interest Videos	☐	☐	☐	Going outdoors	☐	☐	☐
Games	☐	☐	☐	Talking/Listening	☐	☐	☐
Exercise	☐	☐	☐	Gardening/Plants	☐	☐	☐
Sports	☐	☐	☐	Social Events/Parties	☐	☐	☐
Reading/Writing	☐	☐	☐	Watching TV/Movies	☐	☐	☐
Arts/Crafts	☐	☐	☐				

I may like to join the following Clubs and Events: (circle or place a check by all that apply)

History Club ☐ Book Club ☐ Watercolor Class ☐ Bible Study ☐
Geography Club ☐ Cooking Club ☐ Resident Council ☐ Art Museums ☐
Auxiliary Club ☐ Walking Club ☐ Welcoming Committee ☐

My Pets: _____

Childhood Memories:

Accomplishments: _____

Topics I enjoy talking about: _____

Topics that might upset me: _____

My father's name: _____ My Mother's name: _____
Siblings: _____
Spouse: _____ Children: _____

Other information that you should know about me. Please list any known trauma your loved one may have experienced. For example: PTSD from wartime, childhood abuse, domestic violence, etc.:

Signature: _____ Date: _____

Financial Qualification Form

(Private Pay, *Residential Care* Applicants must fill out this form)

Dear Applicant and Responsible Party,

Thank you for your interest in the **James L. West** for your loved one.

James L. West *is a not-for-profit organization and is the preeminent center in North Texas for enhancing the lives of people with Alzheimer's disease and supporting the healthcare professionals and loved ones who treat and care for them.*

It is important that we are fully transparent about the cost of living in our community.

As you may know, Medicare and Medicaid DO NOT pay for Dementia Care at James L. West. However, if you have a long-term care insurance policy, we are happy to help you complete the forms for reimbursement. In order for us to be fiscally responsible and good stewards of our funds, we require that applicants be able to show proof of income and assets to support their loved one for 2 or more years of care. Therefore, we ask that each applicant complete the attached income/asset disclosure form. This form will be considered with your application for admission.

As a not-for-profit organization, our foundation does have some donor funds that can be used to supplement a person's care. These funds are limited and dispersed by our Board of Directors as available and with demonstrated need. Our policy requires that a person live at **The West Center** for 2 or more years before they will be considered for assistance. In addition to tenure, we consider the level of income and assets available to pay for care.

***Disclosure:** By completing and signing the disclosure form (on back), you agree that you have listed all income and assets held by and/or available for the care of the prospective resident. You also agree that you have funds to pay for your loved ones care and that you will not ask for assistance from our foundation within the first 2 years.

Signature of Responsible Party: _____
*Disclosure Form on Back of this page

Waiver: We understand that there are times when a person is uncomfortable to disclose their income and assets. By signing this waiver, you are agreeing that you have available to you the income and assets to pay for your loved ones care, no matter how long that will be. **You agree to NOT request financial assistance from the James L. West during this loved ones stay.**

Signature of Responsible Party: _____

Income and Expenses

RESIDENT NAME		Date	
NAME OF PERSON COMPLETING THIS FORM			

Monthly Income

MONTHLY INCOME

Social Security		
Pension/Retirement Funds		
Interest and/or Dividends		
Family Assistance		
Other income:		
Other income:		
Net Income		0.00

MONTHLY EXPESNSES

Resident Expenses		
	Medications	
	Other Medical expenses	
	clothing and supplies	
	Insurance premiums	
	Monthly Fee to James L West	
Spouse Expenses (if applicable)		
	Mortgage or Rent	
	Utilities	
	Groceries and household expense	
	Medical Expense	
	Medication Expenses	
	Insurance premiums	
	Auto Expenses	
	Life Insurance policies	
	Other:	
	Oher:	
	Other:	
Total Expenses		0.00
Net Income		0

ASSETS

Type of Account	Name or location of account	Balance	Annual Income/dividends		
checking					
Savings					
Stocks/Bonds					
Real Estate					
Value of Home					
Value of vacation homes					
IRA/CD					
Retirement Fund					
Mutual Fund					
Whole Life					
Other					
Totals		0.00	0.00		

JAMES L. WEST ALZHEIMER'S CENTER
1111 Summit Avenue ♦ Ft. Worth, TX 76102
817/877-1199 ♦ (fax) 817-877-1414

Authorization To Use Or Disclose Health Information

I_____ (legal representative) authorize

_____ (facility/physician) to use and/or disclose the health information of _____(resident name/DOB) to James L. West Center for Dementia Care (facility/physician) for the following purpose(s):

☐ Another Facility X Continuing Care ☐ Personal Files ☐ Insurance ☐ Legal

By checking (√) the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist, for the time period of _____ through current:

X_____ History and Physical
X_____ Nurses Notes
X_____ Immunization Record
☐_____ Other _____
X_____ Social Service Notes
X_____ Laboratory Reports
X_____ Physician Orders

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do by submitting a written request to James L. West Alzheimer's Center. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: 30 days from date of signature.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

_____

Signature of Resident or Legal Representative **Date**

_____

If Signed by Legal Representative, Relationship to Resident

Revised Date: August 3, 2018