



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:

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	
NAME OF PERSON COMPLETING THIS FORM	

Date	
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Monthly Income

MONTHLY INCOME

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

	0

MONTHLY EXPENSES

- 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:

	0

Total Expenses

Net Income

0
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	0		

