Dear Prospective Resident:

We thank you for choosing Santa Teresita's Good Shepherd Cottage Assisted Living as your choice of residence and care. Our Admission's Department would like to assist you in gathering all the needed documentation to complete your application process. In order to help you, here is a checklist of the items you will need to include with the submission of your application:

- ☐ Completed Application (5 pages)
- ☐ Last month's bank statement as well as prior year tax return
- ☐ $500.00 **non-refundable** application processing fee
- ☐ Pre-Placement Appraisal Form (2 pages)
  (This form is a tool to gather important information on a prospective resident. Please answer all questions included on the form to the best of your knowledge.)

- ☐ Completed Physician's Report with recent TB skin test results (6 pages)
- ☐ Current list of medications with MD signature
- ☐ Copies of insurance and ID Cards:
  - Social Security Card
  - Medicare Card and/or HMO, PPO Card
  - Medicare Supplemental card
  - RX/Drug Care
- ☐ Durable Power of Attorney for Healthcare
- ☐ Power of Attorney for Finances

Should you have any questions or concerns during the application process, we are available to assist you; please do not hesitate to contact us.

Santa Teresita Admissions Department
***Phone: Office 626.932.3494* | *Cell 626.633.6134* | *Fax*: 626.301.0399**

Date: _______________

Good Shepherd Cottage Assisted Living
RCFE License #198602600
1218 Royal Oaks Dr. | Monrovia, CA 91016

On the Santa Terestia Campus
819 Buena Vista Street | Duarte, CA 91010

Residential Application

Applicant Name:

____

Last Name **First Name** **Marital Status**

____

Address City/State Zip Code

____

Telephone # Place of Birth Date of Birth

____

Social Security # Medicare # MediCal #

____

Name of Secondary Insurance Group # I.D. #

____

Name of HMO Group # I.D. #

Medical Power of Attorney Agent:

____

Name Telephone #

____

Address

Financial Power of Attorney Agent: (Financial Form must accompany application.)

____

Name Telephone #

____

Address

Primary Care Physician:

____
Name Telephone #

____
Address

Executor of Estate:

____
Name Telephone #

Mortuary:

____
Name Telephone #

Pre-admission Living Arrangement: Private Home/ Apt Alone ☐ Private Home/ Apt with other ☐

Another Assisted Living ☐ Skilled Nursing ☐ Other ☐

* If coming from another facility, please give name: ____

Former Occupation: ____

Church Affiliation/ Religious Preference: ____

Residential Application- Statement of Financial Condition

APPLICANT NAME (*please print*):

____

Last Name **First Name** **Date**

MONTHLY INCOME

Social Security ______________________________ Amount ____________________________

Pensions (Source) ____________________________ Amount ____________________________

Annuities _____________________________________ Amount ____________________________

Rental Income _________________________________ Amount ____________________________

ASSETS

Cash ____ Amount ____________________________

Checking ______________________________________ Amount ____________________________

Banking Institution:________________Account #_______________Description:___________________

Savings _______________________________________ Amount ____________________________

Banking Institution:________________Account #_______________Description:___________________

Investment Portfolio ___________________________ Amount ____________________________

Banking Institution:________________Account #_______________Description:___________________

Life Insurance (whole life) _____________________ Amount ____________________________

Stocks and Bonds: ______________________________ Amount ____________________________

Description: ____

Burial Insurance: ______________________________ Amount ____________________________

Burial Plot: ___________________________________ Amount ____________________________

Properties:

Type ____ Value ____________________________

Other ____ Amount ____________________________

LIABILITIES

Loans/Mortgages _______________________________ Amount ____________________________

Credit Cards __________________________________ Amount ____________________________

Judgment Creditors ____________________________ Amount ____________________________

A copy of last year's tax return and most recent bank statement must be submitted with this application.

Signature of Resident/ Responsible Party: ____

Assisted Living Resident Criteria Acknowledgement

(References: from Title 22 87459, 87455, 87465, 87611-87631)

1) Resident should be at least 60 years of age, and able to adapt to community.
2) Residents may only be accepted who require incidental medical services including, but not limited to those specific situations specified in Title 22, Division 6, Chapter 8, Sections 87611 through 87631, of the Manual of Policies and Procedures for Residential Care Facilities For the Elderly:
   a. Residents with the following conditions or care requirements may be admitted provided care is administered i n accordance with attending physicians orders and the Resident can determine need for service and do self-care or care is provided by an appropriately trained skilled nursing professional approved by the Department of Social Services: oxygen, IPPB machine, colostomy or ileostomy, and indwelling urinary catheter, incontinence, diabetes, or injections.
   b. Healing wounds where care is performed by or under the supervision of a skilled medical professional, and is approved by the Department of Social Services.
   c. Hospice care if license has a waiver and the RCFE administrator approves.
3) The following health conditions are prohibited in residential care:
   a. Gastrostomy care, liquid oxygen, naso-gastric tubes, serious infections.
   b. Residents who depend on others to perform all activities of daily living as set forth in Section 87584.
4) Resident agrees to design with staff a Service Plan, which is to be reviewed by-annually or as needed.
5) Resident agrees to abide by agreed upon services.
6) Resident is able to transfer from bed to chair independently.
7) Resident is able to self-manage bowel care.
8) Resident is able to transport self to dining room with or without mechanical aide.
9) Resident is able to feed self without assistance.
10) Resident has safety awareness.
11) Resident can follow directions to evacuate building.
12) Resident has the mental acuity to communicate to staff and to operate the emergency call device.
13) Resident has not indicated a propensity to wander.
14) Resident agrees to relocation if the established criteria can no longer be met, and/or the residential level of care cannot meet the needs of the Resident. If Resident cannot pay for additional needed services and qualifies for Medi- Cal Long Term Care, Resident agrees to transfer to skilled nursing.
15) Family may assist Resident financially to pay for any residential costs.

By signing below I am acknowledging that I have been informed about the criteria for admission to Bethany Assisted Living according to California State Regulations in Title 22. I understand that eligibility for residence is determined according to these regulations and facility policy. If at anytime I am no longer eligible to reside in Assisted Living, I will be assisted to find other residence.

Signature of Resident and/or Responsible Party:

Signature: ____Date: _________________

Assisted Living Application Fee Acknowledgement

We thank you for choosing Santa Teresita's Assisted Living as your first choice of residence and care.

It is our policy to charge $500.00 **nonrefundable** application fee to process your Assisted Living Application. This fee covers the associated costs of processing and evaluating the application materials only. We are not able to begin consideration of admission until the processing fee is paid. This fee is not associated with, or applicable to, any terms of acceptance into the Assisted Living Facilities, or any other level of care, at Santa Teresita.

I agree the application fee of $500.00 is not refundable even if my application is denied or I don't meet the admission criteria for Assisted Living.

____

Resident's Name (Print) Date

____

Signature of Resident and/or Responsible Party: Date

____

Santa Teresita Representative Date

Pre-Placement Appraisal

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 most of the time ☐ In bed part of the time

Comments on bed status:

TUBERCULOSIS INFORMATION:

ANY HISTORY O F TUBERCULOSIS IN APPLICANT'S FAMILY? ☐ Yes ☐ No

DATE OF TB TEST: __________ ☐ POSITIVE ☐ NEGATIVE

ACTION TAKEN (IF RESULTS WERE POSITIVE):

ANY RECENT E X P O S U R E TO ANYONE W I T H TUBERCULOSIS? Yes No

GIVE DETAILS:

AMBULATORY S T A T U S (This person is ☐ ambulatory ☐ non-ambulatory)

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 (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 ☐ Yes ☐ No

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? (If Yes, please attach comments on separate sheet). YES ☐ NO ☐

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

SIGNATURE (Person Completing Form): ____________________ **DATE COMPLETED:** ____________

APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE SIGNATURE: ____________________
DATE COMPLETED: ____________________

LICENSEE OR DESIGNATED REPRESENTATIVE: ____________________**DATE COMPLETED:** ____________