### Standards for Admission

<table>
<thead>
<tr>
<th>Will accept residents with:</th>
<th>Will not accept residents with:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIAGNOSIS:</strong></td>
<td><strong>DIAGNOSIS:</strong></td>
</tr>
<tr>
<td>Lithium with lab monitoring</td>
<td>Insulin dependent diabetics</td>
</tr>
<tr>
<td>Psych diagnoses managed by medication</td>
<td>Blood sugar monitoring</td>
</tr>
<tr>
<td>MRSA wound</td>
<td>Confused residents that wander</td>
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</tbody>
</table>

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<tr>
<th>CARE:</th>
<th>CARE:</th>
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</thead>
<tbody>
<tr>
<td>Peg tubes with bolus feeding only</td>
<td>Suction</td>
</tr>
<tr>
<td>Colostomy</td>
<td>Ventilator support</td>
</tr>
<tr>
<td>Urostomy</td>
<td>Active alcohol or drug addiction</td>
</tr>
<tr>
<td>Chest tubes that hospice staff manages</td>
<td>Electric wheelchair or scooter-</td>
</tr>
<tr>
<td>Foley catheter</td>
<td></td>
</tr>
<tr>
<td>Injections done by hospice staff</td>
<td></td>
</tr>
<tr>
<td>Wounds with simple dressing changes</td>
<td></td>
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<tr>
<td>Trach without suction</td>
<td></td>
</tr>
<tr>
<td>O2 Therapy/CPAP/BIPAP</td>
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</tbody>
</table>

**Applicant must have:**

- Limited financial resources. Each will be considered on an individual basis.
- No willing, available, or competent caregiver.
- Care provided by a hospice team.
- DNR-CC order per State of Ohio form
- Results of a chest X-Ray or TB test performed within the past 6 months.
- Funeral arrangements made in advance.
APPLICATION FOR RESIDENCY

Malachi House, created out of a Christian sense of ministry, serves persons who are terminally ill, without cost or regard to gender, race, religion or national origin. This home ministers to individuals who need an available caregiver, who have limited or no financial resources and are in need of special home care in the final stages of life. A trained staff and volunteers provide spiritual, emotional, and physical support with the assistance of a hospice team.

Name: ___________________________________________ Phone: ____________________________
Address: _______________________________________________________________________________
SSN: ___________________________ Date of Birth: ____________________________
Age: ____________ Sex: ____________ Ethnicity: ______________________________________________

DIAGNOSIS:
What is your primary diagnosis?: __________________________________________________________

Do you have:

- Tuberculosis
  - Yes
  - No
- Feeding Tube
  - Yes
  - No
- Insulin dependent diabetes
  - Yes
  - No
- I.V.
  - Yes
  - No

Do you require:

- Sub Q Medication
  - Yes
  - No
- Injectable Medication
  - Yes
  - No

- Respirator/Trach
  - Yes
  - No

WE DO NOT TAKE INSULIN DEPENDENT/GLUCOSE-MONITORED RESIDENTS

HOSPICE:
Are you in a hospice program now?           Yes           No
If no, are you willing to enter a hospice program? Yes           No
If yes, what is the name of the hospice? ______________________________________________________

CAREGIVER:

Do you have a caregiver now?           Yes           No
If yes, who is your caregiver? ________________________________________________________________

Caregiver phone: ___________________________ Caregiver address: __________________________________________
If your caregiver is no longer willing or able to take care of you please explain:

POWER OF ATTORNEY:

Do you have a health care P.O.A.? Yes_______ No_______ HC P.O.A Phone: _____________________________
General/Financial Health Care P.O.A. Name: __________________________________________________________
P.O.A. Address: __________________________________________________________________________________
**FINANCIAL FORM**

(This information will be used **ONLY** to determine eligibility)

<table>
<thead>
<tr>
<th>Medicare #: __________________________</th>
<th>Medicaid #: ____________________________</th>
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<tbody>
<tr>
<td>Total monthly income: $___________</td>
<td>from ☐ SSI or SSD ☐ Pension ☐ other</td>
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<tr>
<td>Total monthly expenses: $__________</td>
<td></td>
</tr>
<tr>
<td>Savings account</td>
<td>Yes No</td>
</tr>
<tr>
<td>IRA, 401k, Investments</td>
<td>Yes No</td>
</tr>
<tr>
<td>Stocks, Bonds</td>
<td></td>
</tr>
<tr>
<td>Checking Account</td>
<td>Yes No</td>
</tr>
<tr>
<td>Do you own: home/property?</td>
<td>Yes No</td>
</tr>
<tr>
<td>1st mortgage balance: $___________</td>
<td>2nd mortgage balance if applicable $________</td>
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**ATTACHMENTS:**

The following items MUST be attached to the application:

- Completed & Signed DNR Form
- Current Chest X-Ray (within 6 months)
- Malachi House Transfer Form
- History & Physical

**REPORT CALLED ON DAY OF ADMISSION**

**IS RESIDENT A VETERAN?** Yes No

**FUNERAL HOME ARRANGEMENTS NEED TO BE IN PLACE BEFORE ADMISSION:**

- Name of Funeral Home: __________________________
- Address: _____________________________________________
- Telephone: ___________________________________________

I understand and agree that my residency at Malachi House may be re-evaluated at any time for changes in diagnosis, prognosis, or behavior. The information I have provided here is true and accurate to the best of my knowledge.

_______________________________   ______________________________
Applicant                       Person Signing for Applicant

_______________________________   ______________________________
Date                            Date

**Office Use Only**

Approved By: ____________________________ Date: ____________________________

**ALL AREAS MUST BE COMPLETED**
REFERRAL INFORMATION FORM

A loving home for life’s last journey

Patient Name: ____________________________________________________________ SSN: ____________________________

Home Address: _______________________________________________________________________________________________

City: _________________________________________________ State: _____________________   Zip: _______________________

County: ______________________________________________________ Date of Birth: ___________________________

Marital Status:  ○ Single  ○ Married  ○ Divorced  ○ Widowed  ○ Separated

Religion: ___________________________________________ Church: _________________________________

MEDICAL INFORMATION:

Principal Diagnosis (include date of onset): ________________________________________________________________

Other Diagnosis: ______________________________________________________________________________________________

Prognosis: _____________________________________________________________________________________________________

Allergies: _______________________________________________________________________________________________________

Brief history/course of treatments/tests/surgeries (include dates): _____________________________________

__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________

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Test:  Date:  Result:

Chest X-Ray  __________  ________________ ATTACH A COPY TO THIS APPLICATION

PPD  __________  ________________ ATTACH A COPY TO THIS APPLICATION

MRSA  ○ Yes  ○ No  Site: ________________________________

MEDICATION

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Does patient refuse to take medications: Yes____  No ____  Sometimes____

Diet: ______________________________ Consistency: ______________________________

Referral Made By: ______________________________ Date: ______________________________

ALL AREAS MUST BE COMPLETED
ALL AREAS MUST BE COMPLETED

**PRESENT PATIENT LOCATION:**
If not in hospital, present patient location: ____________________________________________
Present address: ____________________________________________________________________
Contact: ___________________________ Phone: ______________________________

**HEALTH CARE POWER OF ATTORNEY:**
Name: ___________________________________________________________________________
Address: _________________________________________________________________________
Relationship: __________________________ Phone: _____________________________

**FAMILY / FRIEND / GUARDIAN:**
Name: ___________________________ Relationship: ___________ Address: ________________
Phone: ____________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

**COMMUNITY AGENCIES ACTIVE WITH PATIENT:**
Agency Name: ___________________ Staff: ___________ Phone: _______________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

**SOCIAL SERVICE ASSESSMENT / RESIDENT OR FAMILY:** Please comment on each
Family relationship/support: ___________________________________________________________________
Home environment (physical & social): __________________________________________________________
Over the past six months have the resident, family, or hospice team noticed a problem with:

- Lice: ______________________________________________________________________________
- Bedbugs: ___________________________________________________________________________
- Cockroaches: _________________________________________________________________________
- Other: _____________________________________________________________________________

Sitter/Restraints-Free minimum of 24 Hours: ________________________________________________
Cognitive/Emotional/Coping Status: _________________________________________________________
Additional problem areas: __________________________________________________________________
History of Smoking: ______________________________________________________________________
History of alcohol abuse: ___________________________________________________________________
History of drug abuse: _____________________________________________________________________
Psych history: ___________________________________________________________________________
History of domestic violence: _______________________________________________________________

**SW/RN signature:** ____________________________________________________________________

ALL AREAS MUST BE COMPLETED
**RESIDENT PSYCHO-SOCIAL HISTORY**

**MALACHI HOUSE**
A loving home for life’s last journey

<table>
<thead>
<tr>
<th>Patient Name: _______________________________</th>
<th>Admit Date: _____________________________</th>
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<tbody>
<tr>
<td>Social Worker: ______________________________</td>
<td>Phone: _________________________________</td>
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<tr>
<td>Diagnosis: ______________________________________________________________________________</td>
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<td>Other disease processes (physical/psychological): ____________________________________________</td>
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**FUNCTION LEVEL:**

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<thead>
<tr>
<th>Physical:</th>
<th>Psycho-social:</th>
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**MENTAL:**

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<tr>
<th>Alert</th>
<th>Lethargic</th>
<th>Comatose</th>
<th>Oriented</th>
<th>Disoriented</th>
<th>Confused</th>
<th>Dementia</th>
<th>Forgetful</th>
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**AFFECT:**

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<tr>
<th>Cheerful</th>
<th>Superficially Cheerful</th>
<th>Calm</th>
<th>Hostile</th>
<th>Flat, Blunted</th>
<th>Fearful</th>
<th>Anxious/Agitated</th>
<th>Depressed</th>
<th>Tearful</th>
<th>Other (explain)</th>
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**ATTITUDE & BEHAVIOR:**

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<thead>
<tr>
<th>Disruptive</th>
<th>Helpful</th>
<th>Thoughtful</th>
<th>Withdrawn</th>
<th>Resistive</th>
<th>Immature / Regressed</th>
<th>Aggressive</th>
<th>Preoccupied</th>
<th>Manipulative</th>
<th>Seeks reassurance</th>
<th>Seeks attention</th>
<th>Anxious</th>
<th>Other (explain)</th>
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**ACTIVITY:**

<table>
<thead>
<tr>
<th>Ambulatory Ad Lib</th>
<th>Ambulatory w/Assist</th>
<th>Assistive Device</th>
<th>Transfer to bed</th>
<th>Bedbound</th>
</tr>
</thead>
<tbody>
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**VERBILIZATION:**

<table>
<thead>
<tr>
<th>Non-Verbal</th>
<th>Verbalized only when questioned</th>
<th>Verbalized spontaneously</th>
<th>Other (explain)</th>
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**RELEVANT HISTORY, CURRENT DYNAMICS, CURRENT ISSUES:**

__________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________

**FAMILY:**

Spouse: __________________________________________ Parents: __________________________________________

Children: ______________________________________________________________________________________________________

_______________________________________________________________________________________________________________________

Siblings: _______________________________________________________________________________________________________

_______________________________________________________________________________________________________________________

Other: ___________________________________________________________________________________________________________

_______________________________________________________________________________________________________________________

**ALL AREAS MUST BE COMPLETED**
NURSING SUMMARY:
Cardio-Pulmonary:
Temp: ___________ ○ O ○ Ax ○ R ○ Secretions
Pulse: ___________ ○ AP ○ R ○ Quality Describe: ________________________________
BP: ___________ ○ R ○ L ○ Tracheostomy
Resp: ___________ Depth and Quality: ___________ Size: _________ Type: ___________
Oxygen Used/Breathing Treatment: ___________ Rate: ___________ Method: ___________

NUTRITION / HYDRATION:
Height: ___________ ○ Feeds Self ○ Dehydration
Weight: ___________ ○ Assist Feed ○ Edema ○ Teeth
○ No Teeth ○ Consistency: ○ Hyperalmentation ○ Vomiting ○ Edema
○ Dentures Type ○ Feeding Tube Type ○ Dysphagia ○ Teeth
○ Denture with Patient ○ Date Inserted: ___________

SENSORY / COMFORT:
VISION: ○ Adequate ○ Adequate ○ Good ○ Pain ○ Yes ○ No
Poor ○ Poor ○ Difficult ○ Where/When: __________________
Blind ○ Blind ○ Unable ○ PT has them ○ Yes ○ No
Glasses ○ Glasses ○ Language: ○ PT uses them ○ Yes ○ No
Contacts ○ Contacts ○ In Ear ___________ ○ Other – specify: ______________________________________

PSYCHOSOCIAL:
MENTAL STATUS: ○ Alert ○ Wanders ○ Flat ○ Lives with others
Lethargic ○ Cooperative ○ Calm ○ Lives alone
Comatose ○ Combative ○ Anxious ○ Gets help from others
Oriented ○ Forgetful ○ Unlabeled ○ Other: ___________
Disoriented ○ Sleep Problems ○ ___________
Confused ○ Other – specify: ______________________________________

ELIMINATION:
BLADDER:
Continent ○ Continent ○ Independent ○ Toilet
Incontinent ○ Incontinent ○ Dependent ○ Bedpan
Retention ○ Constipation ○ Ostomy ○ Catheter
Frequency ○ Diarrhea Type: ___________ ○ Foley
Dribbling ○ Last BM: ___________ ○ Appliance: ___________ ○ Urostomy

BOWEL:
Continent ○ Continent ○ Independent ○ Toilet
Incontinent ○ Incontinent ○ Dependent ○ Bedpan
Retention ○ Constipation ○ Ostomy ○ Catheter
Frequency ○ Diarrhea Type: ___________ ○ Foley
Dribbling ○ Last BM: ___________ ○ Appliance: ___________ ○ Urostomy

SKIN:
Skin Intact ○ Yes ○ No
Describe any impairments:
Size: ___________ ○ Site: ___________ ○ Drainage: ________________________________

HYGEINE / MOBILITY:
Used:
Oral Care ○ Independent ○ Assist ○ Total Dependent ○ ___________
Bathing: ○ Independent ○ Assist ○ Total Dependent ○ ___________
Dressing: ○ Independent ○ Assist ○ Total Dependent ○ ___________
Wheelchair: ○ Independent ○ Assist ○ Total Dependent ○ ___________
Transfer: ○ Independent ○ Assist ○ Total Dependent ○ ___________
Ambulation: ○ Independent ○ Assist ○ Total Dependent ○ ___________
Amputation ○ Contractures ○ Paralysis ○ Paresis ○ Other ○ ___________

SAFETY:
○ Fainting ○ Dizziness ○ Headaches ○ Seizures ○ Weakness

Signature: ________________________________ Date: ________________________________

ALL AREAS MUST BE COMPLETED