

Lavender Hills
Assisted Living LLC
License #'s: 455002027 & 455002615

Admission Assessment Form

Please fill out the entire form as this will help us know if the resident is suitable for our facility.

RESIDENTIAL CARE FACILITY FOR THE ELDERLY

PRE-ADMISSION QUESTIONNAIRE

The following questionnaire is designed to assist licensees in identifying specific medical and behavioral issues that may affect the placement of and/or services to be provided to prospective residents of Residential Care Facilities for the Elderly (RCFE). The questions on this form should be reviewed with the applicant's responsible party prior to admission to the facility. If the answer to any of the questions on this list is yes; the licensee should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs. It is essential for licensees to ensure, to the extent possible, that the resident's history, medical assessment, prior facility records, if applicable and existing conditions are known and care needs understood prior to admission.

This guide is not intended to be a substitute for reading and understanding the regulations. The regulation section is referenced after each question.

The information on this form supplements the Preplacement Appraisal Information form (LIC 603), but does not replace it. While the information gathered from this form should assist licensees in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date: _____

Applicant's Name: _____ Date of Birth: _____

Current Residence:

Own home _____ With family _____ Board & Care _____

Skilled nursing facility _____ Hospital _____

Reason(s) for Placement in RCFE: _____
_____
_____
_____

Applicant's Physician: _____
Address: _____
Phone number: _____

Applicant's Responsible Person, (if applicable) _____

A. INCIDENTAL MEDICAL SERVICES ASSESSMENT

YES **NO**

1. Oxygen Administration

☐ ☐ Does the applicant use oxygen? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant use liquid oxygen? If yes, explain. _____

_____

_____

_____

2. Intermittent Positive Pressure Breathing (IPPB) Machine

☐ ☐ Does the applicant use an IPPB? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

3. Colostomy/Ileostomy

☐ ☐ Does the applicant have a colostomy or ileostomy? If yes, explain. _____

_____

_____

_____

YES **NO**

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

4. Enema/Suppository/Fecal Impaction Removal

☐ ☐ Does the applicant need enemas, suppositories or fecal impaction removal? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

5. Catheter Care

☐ ☐ Does the applicant have a catheter? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

6. Bowel and Bladder Incontinence

☐ ☐ Is the applicant incontinent of bowel or bladder? If yes, explain. _____

_____

_____

_____

7. Contractures

☐ ☐ Does the applicant have contractures? If yes, explain. _____

_____

_____

_____

YES **NO**

☐ ☐ Does the applicant need assistance? If yes, explain. _____

_____

_____

_____

☐ ☐ Do the contractures severely affect the applicant's ability to function? If yes, not allowed in an RCFE._____

_____

_____

_____

8. Diabetes

☐ ☐ Does the applicant have diabetes? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant require assistance with performing or reading glucose tests, drawing up injectable medications or administering injections? If yes, explain. _____

_____

_____

_____

9. Injections

☐ ☐ Does the applicant need any injections? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant need assistance with drawing up and administering the injections? If yes, explain._____

_____

_____

_____

YES **NO**

10. Healing Wounds

☐ ☐ Does the applicant have any healing wounds? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant have stage 1 or 2 dermal ulcers (bedsores)? If yes, explain. _____

_____

_____

_____

☐ ☐ Does the applicant have stage 3 or 4 dermal ulcers? If yes, not allowed in an RCFE unless an exception is approved.

11. Bedridden

☐ ☐ Is the applicant bedridden – unable to reposition or transfer in bed? If yes, please explain. _____

_____

_____

_____

☐ ☐ Is the applicant unable to transfer in and out of bed without assistance? If yes, explain. _____

_____

_____

_____

☐ ☐ Is the applicant's bedridden status temporary (less than 14 days)? If yes, explain. _____

_____

_____

_____

☐ ☐ Is the condition permanent or expected to last more than fourteen days? If yes, explain. _____

_____

_____

_____

YES **NO**

12. Gastrostomy

☐ ☐ Does the applicant have a gastrostomy? If yes, not allowed in an RCFE unless an exception is approved.

13. Naso Gastric (NG) Tubes

☐ ☐ Does the applicant have NG tubes? If yes, not allowed in an RCFE.

14. Staph Infection

☐ ☐ Does the applicant have a Staph or other serious infection? If yes, not allowed in an RCFE unless an exception is approved.

15. Total Care

☐ ☐ Does the applicant need total care (assistance with ALL activities of daily living-- eating, bathing, dressing, grooming, toileting and transferring)? If yes, not allowed in an RCFE unless an exception or waiver is approved.

16. Tracheostomies

☐ ☐ Does the applicant have a tracheostomy? If yes, not allowed in an RCFE.

17. Hospice

☐ ☐ Is the applicant currently receiving hospice care? If yes, please see Self-Assessment Guide on Hospice Care.

B. PERSONS WITH DEMENTIA

YES **NO**

☐ ☐ Does the applicant have Dementia?

☐ ☐ Is the applicant mentally able to respond to an emergency signal or instruction? If yes, explain. _____

_____

_____

_____

YES **NO**

☐ ☐ Is the applicant mentally unable to respond to an emergency signal or instruction? If yes, explain. _____

_____

_____

_____

C. BEHAVIORAL ASSESSMENT

Does the applicant have a history of any of the following behaviors?

YES **NO**

☐ ☐ 1. Physical assaultiveness

☐ ☐ 2. Verbal assaultiveness

☐ ☐ 3. Wandering

☐ ☐ 4. Sexual assaultiveness, molestation or inappropriate sexual activity

☐ ☐ 5. Disruptiveness (screaming, throwing things, argumentative)

☐ ☐ 6. Property destruction

☐ ☐ 7. Careless disposal of smoking materials

☐ ☐ 8. Stealing

If the answer to any of the above is yes, describe the behavior: _____

_____

_____

_____

Frequency and duration of the behavior(s): _____

_____

_____

_____

Approximate date of last occurrence: _____

_____

_____

_____

What seems to trigger the behavior: _____

_____

_____

_____

Strategies to deal with the behavior: _____

_____

_____

_____

Does the applicant have a history of any of the following behaviors?

YES	NO	
☐	☐	1. Refusal to take medication
☐	☐	2. Refusal to get medical attention
☐	☐	3. Refusal to bathe or wear clean clothing
☐	☐	4. Non-compliance with house rules
☐	☐	5. Self-abuse
☐	☐	6. Suicide attempts or suicidal thoughts
☐	☐	7. Depression
☐	☐	8. Alcohol or drug abuse

If the answer to any of the above is yes, describe the behavior: _____

_____

_____

_____

Frequency and duration of the behavior(s): _____

_____

_____

_____

Approximate date of last occurrence: _____

_____

_____

_____

What seems to trigger the behavior: _____

_____

_____

_____

Strategies to deal with the behavior: _____

_____

_____

_____

D. MISCELLANEOUS

YES **NO**

☐ ☐ 1. Does the applicant currently use any prescription or over-the-counter medications? If yes, please list.

Medication Name	Strength	Dose	Times

☐ ☐ 2. Does the applicant currently use any prescription or over-the-counter medications on a PRN basis? If yes, please list. _____

_____

_____

_____

☐ ☐ 3. Does the applicant have any emergency medication that must be kept with him/her or at bedside? If yes, please list. _____

_____

_____

_____

☐ ☐ 4. Will the applicant be willing to have all of his/her medications, including over-the-counter medications, centrally stored?

YES **NO**

5. Does the applicant use any of the following devices?

☐ ☐ Glasses
☐ ☐ Dentures
☐ ☐ Hearing Aid
☐ ☐ Other _____

6. Does the applicant need assistance with any of the following?

☐ ☐ Eating. If yes, explain. _____
_____
_____
_____

☐ ☐ Bathing. If yes, explain._____
_____
_____
_____

☐ ☐ Dressing. If yes, explain._____
_____
_____
_____

☐ ☐ Grooming. If yes, explain._____
_____
_____
_____

☐ ☐ Toileting. If yes, explain._____
_____
_____
_____

7. Does the applicant use any of the following?

☐ ☐ Cane. If yes, explain.
_____
_____
_____

☐ ☐ Crutch. If yes, explain._____
_____
_____
_____

YES **NO**

☐ ☐ Walker. If yes, explain. _____
_____
_____
_____

☐ ☐ Wheelchair. If yes, explain.
_____
_____
_____

☐ ☐ 8. Does the applicant have any paralysis? If yes, explain (site, degree, assistance needed)
_____
_____
_____

☐ ☐ 9. Does the applicant require a special diet? If yes, explain. _____
_____
_____
_____

☐ ☐ 10. Does the applicant have any skin condition or history of skin breakdown? If yes, explain. _____
_____
_____
_____

☐ ☐ 11. Will the applicant require transportation to any appointments or events other than routine local medical appointments? If so, where and how often? _____
_____
_____
_____

Applicant/Responsible Person: _____
(Signature)

Date: _____

Facility Representative: _____
(Signature)

Date: _____

Attachments:

☐ **YES** ☐ **NO**

Questions For Move In Paperwork

Name: _____

Room #_____House #_____

Room Size: _____ Rent $ _____ Level: _____

Date Of Admission: _____ Move In Date: _____

1. DOB: _____

2. Medication Allergies: _____

3. Food Allergies: _____

4. Current Pharmacy _____ Switch To
   CWD: Yes or No

5. Photo: YES NO Not Sure At This Time

6. Favorite Color/Nick Name For Room Sign: _____ _____

7. Furniture Wanted: Dresser- Night Stand- Lamp- Twin Bed- Chair

8. Shower Preference: AM or PM or No Preference

9. Current Physician: _____
   Address: _____ Phone: _____ Fax _____

10. DNR Status _____

11. Name And Address Of POA:

    Name: _____
    Address _____
    Phone: _____ Cell: _____
    Relationship: _____

    Email Address for POA: 1st. _____ Medical or Financial
    2nd. _____ Medical or Financial

Relative Details: _____

_____

Items Needed Before Move In:

1. Copies of Insurance cards, Covid Vaccine Card (If available) and ID (front & back)- Copy's of Power of attorney paperwork (if available)

2. Physician Report filled out with TB test completed, over the counter medications sheet, PRN authorization letter and current list of all medications printed and all signed by physician.

3. DNR form completed and signed by Physician and Resident or POA. If resident so chooses. (If resident does not complete a DNR they will be considered a resuscitate)

4. All emergency paperwork filled out and signed by resident or POA and returned.

5. Getting to know you filled out to the best of your ability. Please include brief medical history and social history including number of children, occupation, favorite past time.

6. All medications must be in original bottles(No daily doser) with at least 2 weeks' worth of medication with fully intact labels. No expired medications will be accepted. Although not required, we would greatly appreciate, new sealed bottles of over-the-counter medications be provided to expedite the move in process.

If you have further questions with any of this material, please do not hesitate to call Jenn, at (530) 245-9970.

Thank you,

Jennifer Boss
Administrator

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION

This information is required under the H & S Code and the regulations of the Department to be maintained on every person admitted to a community care facility, to be readily available to the person in charge, but not accessible to unauthorized persons. All information must be kept current. See other side for additional information required for residential facilities for children.

A. ALL FACILITIES [EXCEPT CHILD CARE CENTER/FAMILY CHILD CARE HOME COMPLETES LIC 700]

1. NAME OF CLIENT OR CHILD		SOCIAL SECURITY NUMBER (OPTIONAL)	DATE OF BIRTH	AGE	SEX

2. RESPONSIBLE PERSON OR PLACEMENT AGENCY	ADDRESS	TELEPHONE

3. NAME OF NEAREST RELATIVE (OPTIONAL)	RELATIONSHIP	ADDRESS	TELEPHONE
			( )

4. DATE ADMITTED TO FACILITY	ADDRESS PRIOR TO ADMISSION

5. DATE LEFT	FORWARDING ADDRESS

6. REASONS FOR LEAVING FACILITY

7. **PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, IF ANY**

NAME	ADDRESS	TELEPHONE
		( )
		( )
		( )

8. **OTHER PERSONS TO BE NOTIFIED IN EMERGENCY**

NAME	ADDRESS	TELEPHONE
a. PHYSICIAN		( )
b. MENTAL HEALTH PROVIDER, IF ANY		( )
c. DENTIST		( )
d. RELATIVE(S)		( )
e. FRIEND(S)		( )

9. **EMERGENCY HOSPITALIZATION PLAN**

NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY	ADDRESS OF HOSPITAL TO BE TAKEN IN AN EMERGENCY
MEDICAL PLAN	MEDICAL PLAN IDENTIFICATION NUMBER
NAME OF DENTAL PLAN (IF ANY)	DENTAL PLAN NUMBER (IF ANY)

10. **OTHER REQUIRED INFORMATION**

a. AMBULATORY STATUS

b. RELIGIOUS PREFERENCE	NAME AND ADDRESS OF CLERGYMAN OR RELIGIOUS ADVISOR, IF ANY	TELEPHONE
		( )

11. COMMENTS

Email for emergency contact:

SIGNATURE OF RESIDENT	SIGNATURE OF PERSON COMPLETING FORM	TITLE	DATE

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Adult and Elderly Residential Facilities

AS THE CLIENT, AUTHORIZED REPRESENTATIVE OR CONSERVATOR, I HEREBY GIVE CONSENT TO

Lavender Hills Assisted Living
FACILITY NAME

TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE INDIVIDUAL NAMED ABOVE.

CLIENT HAS THE FOLLOWING MEDICATION ALLERGIES:

DOES NOT EXPIRE
DATE

CLIENT/AUTHORIZED REPRESENTATIVE/CONSERVATOR SIGNATURE
(CIRCLE APPROPRIATE TITLE)

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

RELEASE OF CLIENT/RESIDENT MEDICAL INFORMATION

To: _____ Date: _____

(PHYSICIAN, CLINIC, HOSPITAL, HOSPICE, HOME HEALTH AGENCY, ATTENDING NURSE, PSYCHOLOGIST, COUNSELOR, THERAPIST, ETC.)

_____

(ADDRESS)

I hereby authorize you to release any and all medical or confidential information contained in the record of:

_____

(NAME OF PERSON)

Lavender Hills Assisted Living

(NAME AND ADDRESS OF FACILITY, PERSON OR AGENCY REQUESTING INFORMATION)

THIS AUTHORIZATION SHALL EXPIRE ON: Does Not Expire

(DATE)

_____

(CLIENT OR AUTHORIZED REPRESENTATIVE)

_____

(RELATIONSHIP TO PERSON ON WHOM INFORMATION IS REQUESTED)

_____

(ADDRESS)

NOTE:

1. The person who authorized this release may revoke this authorization at any time.
2. The person who authorized this release has a right to receive a copy of the release.
3. This information is required to conform to CCR Title 22 regulations, to ensure a continuum of care to the resident, client or child. Licensees should maintain a copy of this form in the facility records.
4. The above facility is licensed by the Department of Social Services (or its accredited agencies), and does not provide skilled nursing care.

Resident Pre-Emergency Documentation

Facility Name: Lavender Hills Assisted Living	**Facility phone No:**	
Resident Name:	Age:	DOB:
Responsible Person:	Home Phone:	Cell Phone:
Additional Family:	Home Phone:	Cell Phone:
Physician:	Phone Number:	
Religious Preference:	Funeral Home Preference:	
Current Diagnosis:		
Allergies:		
Current Pharmacy:		

Current Health Conditions/ Past Surgeries

_____

_____

_____

_____

_____

_____

_____

DNR Or Resuscitate

Hospital of Choice: _____

Inventory of Personal Effects

Instructions: Upon admission, please identify the resident's personal belongings by indicating quantity and value of the items listed. Use the space allowed to write in additional items as necessary. We highly recommend getting renter's insurance on any items of high value as Lavender hills is not responsible for lost,stolen or broken items. No cash or credit cards should be kept in room without a lock box. Upon removing any items from the facility, use ✓ columns to indicate that all personal belongings are accounted for. Use a D for items being donated.

Articles **Items of specific Value (Jewelry, Electronics, Furniture)**

✓	QTY.	Articles	Value	✓	QTY.	Description	Value
		Shirts	$			Television	$
		Pants	$			Cd Player/ Radio/Ipods	$
		Pajamas	$			Ipads/Tablets	$
		Jackets	$			Computers/laptops	$
		Gloves	$			Cellphones	$
		Shoes	$			Pictures	$
		Purses	$			Dressers	$
		Hats	$			Clocks	$
			$			Chairs	$
			$			Bed	$
			$			Night stands	$
			$				$
			$				$
			$				$
		Hearing Aides Left ☐ Right ☐	$				$
		Dentures Yes ☐ No ☐	$				$
		Partial ☐ Upper ☐ Lower ☐	$				$
		Glasses	$				$
		Cane	$				$
		Walker	$				$
		Wheelchair	$				$
		Brace	$				$
		Prosthesis	$				$

I am choosing to decline to fill out the personal inventory form and I have been made aware that Lavender Hills Assisted Living LLC will not be at fault for any missing items, and that is our responsibility to have Renters insurance on any items of high value.

X _____ **Date:** _____
Resident or Resident Representative

_____

I have chosen to fill out the Personal inventory form and I will update it as family brings in items

X _____ **Date:** _____
Resident or Resident Representative

X _____ **Date:** _____
Facility Representative

Upon moving from the facility

I have received all of the items that are marked with ✓ I am donating all the items marked with a D to Lavender Hills Assisted Living LLC to do with as they wish.

X _____ **Date:** _____
Resident or Resident Representative

X _____ **Date:** _____
Administrator Signature

X _____ **Date:** _____
Witness signature