MCKINLEY CARE

☐ Dementia Unit ☐ Apartment/Regular Floor

Application Packet

Thank you for your interest in McKinley Care. This application packet is an information-gathering tool that will help us assess the applicant's service needs.

Acceptance into McKinley Care is determined by:

- The applicant's service needs and the ability for our staff to meet those needs.
- The availability of an Apartment or Dementia Room.

Please consider the following before proceeding:

- To reside in our home, one must be at least 21 years old.
- Meals are served in the dining room or apartment.
- Smoking is not allowed on the campus.
- Caregivers are available 24 hours, 7 days a week to assist residents with personal needs.
- Nurses are accessible 24 hours, 7 days a week.
- Coordination, transportation, and escort regarding medical appointments are not provided.
- Pets are not allowed.
- Resident's monthly fee is determined by the level of care he or she requires on a daily basis.
- Persons who have Long Term Care Insurance will need to contact their insurance carrier for prior approval before move-in. We bill as a courtesy but monthly rent is your responsibility.

Prior to move-in, applicant must complete McKinley Care intake process: screening application; meeting with nursing staff to complete Service Plan (approximately 45 minutes to 1 hour); and meeting with Business Manager to review business requirements (approximately 45 minutes to 1 hour). If you need community resource information, we are happy to assist. If you request to be placed on our Wait List, we will keep your application for up to 6 months. If you have any questions about this packet or the intake process, please contact us at (907) 531-6078

Welcome!

Shaw Reyes, RN, BSN
Operations Manager

Please send completed applications to:
337 E 4th Ave Unit B Anchorage AK 99501
Or email them to:
shaw@mckinley.care

Application Packet for McKinley Care ALH

Please complete all areas of this application. Please be as thorough and accurate as possible when filling out this application. ***An incomplete application will delay the process.***

Name	Date of Birth | Age	Social Security Number
Address	Home Phone:	Cellular Phone:
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	☐ Female ☐ Male	Religious Preference
Provide any of the following: ☐Living Will ☐Power of Attorney ☐Comfort One ☐Durable Power of Attorney For Health Care Decision	Are you a Veteran? ☐ Yes ☐ No What branch of the military did you serve under:	
Medicare No.	**Are you on the CHOICE Medicaid Waiver Program?**	
Medicaid No.	☐ Yes ☐ No ☐ Pending	
Personal Insurance Carrier:	**If, yes, who is your Care Coordinator?**	
Group No.	Name:	
Policy No.	Tele: Fax: Email:	
Monthly Income: SSI_____ _ Retirement (pensions, IRA, etc) _____	**How did you hear about us?** ☐Website ☐Newspaper ☐Family/Friend ☐Hospital ☐Other _____	
AK Longevity Bonus: _____ Other income: _____ Who will assist with finances: _____ Send billing statement to: _____	**Do you have Pet (s): ☐ Yes ☐ No** **If, Yes, what type of pet do you have?**_____ **Are you able to take care of your own pet? ☐ Yes ☐ No** **Who will be your back up in case of an emergency?**_____	
Physician (1) Name: _____ Specialty: _____ Address: _____ _____ Tele: _____ Fax: _____	**Emergency Contact (1)** Name: _____ Relationship:_____ Address: _____ _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email (optional):	
Physician (2) Name: _____ Specialty: _____	**Emergency Contact (2)** Name: _____ Relationship:_____ Address: _____	

Address: _____ _____ Tele: _____ Fax: _____	_____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email (optional):

Health Information

Allergy(s):	**Medical Diagnosis/Past Surgery (Attach list if needed):**
Pharmacy: **Mediset Box Setup:** ☐ Pharmacy ☐ Other Name: _____ **Supplies Delivered by**: (i.e., medical equipment, oxygen, incontinent supplies)_____	**Do You Smoke**: ☐ Yes ☐ No (Note: This does not, in any way, preclude you from submitting this application for consideration to reside at our Assist Living Home. However, please be aware we are a non-smoking campus and you must smoke off campus.
Hospital Preference	
Funeral Preference **Name:** **Tele:** **Address:**	

Services Information – Check appropriate box

Do you need help showering? ☐ Independent – no supervision ☐ Needs Assistance ☐ Comment: _____ _____ _____	Are you able to manage your own medication? ☐ Independent – no supervision ☐ Needs Assistance ☐ Comment: _____ _____ _____
Can you dress yourself? ☐ Independent – no supervision ☐ Needs Assistance ☐ Comment: _____ _____	Can you groom yourself? ☐ Independent – no supervision ☐ Needs Assistance ☐ Comment: _____ _____
Are you able to Toilet independently ☐ Continent ☐ Incontinent of ☐ Bladder ☐ Bowel ☐ Independent – no supervision ☐ Needs Assistance ☐ Type of appliance (i.e., ostomy, foley) _____ ☐ Comment: _____ _____	Are you Diabetic/ if so please provide: ☐ Controlled with diet/oral medications ☐ Controlled with insulin _____ times per day ☐ Can self inject insulin ☐ Yes ☐ No ☐ Sliding scale insulin ☐ Yes ☐ No ☐ Blood Sugar Checks _____ times per day ☐ Comment: _____ _____
Sensory Loss ☐ No loss ☐ Limited to moderate vision or hearing loss ☐ Severe vision or hearing loss	Skin Care / Wound Care ☐ Open areas/wounds ☐ MRSA/STAPH/Rashes ☐ Wound dressing/bandages

☐ Comment: _____ _____	☐ Comment: _____ _____

Mobility ☐ Independent – no supervision ☐ Needs Assistance ☐ Comment: _____ _____	Eating ☐ Independent – (can feed self) no supervision ☐ Needs Assistance ☐ Comment: _____ _____
Transfers *(i.e., bed to chair, etc)* ☐ Independent – no supervision ☐ Stand by assist – partial supervision ☐ Full assist - hands on, cueing, prompting, requires a lift ☐ Comments: _____ _____	Communication ☐ No difficulties ☐ Minimal difficulties ☐ Frequent difficulties ☐ Comment: _____ _____

Equipment Usage

Do you own:
- ☐ Wheelchair – Electric or Manual
- ☐ Walker – Standard or 4-wheel
- ☐ Hospital Bed
- ☐ Oxygen
- ☐ Prosthetic: _____
- ☐ Other _____

_____
_____

Community Services

Services used in the past or currently:
- ☐ Senior Center
- ☐ Adult Day Care
- ☐ Home Health Care
- ☐ Personal Care In Home
- ☐ Other_____

_____

Behavior Information

Check all that apply: ☐ Substance Abuse: Alcohol/Drugs/Medication ☐ Smoke – How long? _____ ☐ Depression ☐ Nocturnal Wandering ☐ Hallucinations ☐ Paranoia ☐ Agitation: Hyperactive/Anxious ☐ Danger to Self ☐ Other _____ _____	Cognitive Functioning ☐ Alert ☐ Occasional disorientation-time/place ☐ Occasional disorientation-memory loss ☐ Comment: Behavior ☐ Never combative ☐ Occasionally combative/wandering ☐ Frequently combative/wandering ☐ Comment: _____ _____
Are there environmental or social triggers or events that create laughter, singing, happiness or pleasure? ☐ Yes ☐ No Comment: _____	Are there issues with striking out to hit others? ☐ Yes ☐ No Comment: _____
Are there environmental or social triggers or events that cause sadness or agitation? ☐ Yes ☐ No Comment: _____	Are there issues with pinching or grabbing others? ☐ Yes ☐ No Comment: _____

Behavior Information cont'd

Is there any evidence of hoarding or stealing? ☐Yes ☐No Comment: _____	Is there difficulty interacting with animals/pets? ☐Yes ☐No Comment: _____
Are there any behaviors that may bother others? ☐Yes ☐No Comment: _____	Are there issues with using foul language or verbally threatening others? ☐Yes ☐No Comment: _____
Is there destruction of clothing or property? ☐Yes ☐No Comment: _____	Are there issues with throwing objects? ☐Yes ☐No Comment: _____

"Feelings" (If yes please briefly explain)

Is he/she sad or withdrawn from any activity? ☐Yes ☐No Comment: _____	Is he/she frequently anxious? ☐Yes ☐No Comment: _____
Are feelings expressed with anger? ☐Yes ☐No Comment: _____	Is the anger translated into actions? ☐Yes ☐No Comment: _____

"Perception" (if yes, please briefly explain)

Does he/she recognize himself/herself in a mirror or photo? ☐Yes ☐No Comment: _____	Does this recognition bother him/her? ☐Yes ☐No Comment: _____
Does he/she recognize family members? ☐Yes ☐No Comment: _____	Does he/she complain of/or avoids shinny objects, sunlight, or bright lights? ☐Yes ☐No Comment: _____
Does he/she become distracted with objects on the wall, patterns on a bed or cover, or other environmental textures? ☐Yes ☐No Comment: _____	Are there noises that may or can cause concern or alarm? ☐Yes ☐No Comment: _____
Does he/she confuse reality with TV? ☐Yes ☐No Comment: _____	Does he/she "believe" or describe hallucinations? ☐Yes ☐No Comment: _____

Behavior Mapping

(24-hour snapshot)

To get a clear picture of a day in the life of the applicant, please describe the routine and sequence of a day, including sleep time, eating, use of bathroom, dressing, outings, naps, walking sitting, etc. Share details of his/her current **environment;** TV Show he/she enjoys; how medications are taken, etc.; favorite activities, meals, shower. Share details of what the **caregiver** does to support or assist in this day.

START with morning time and END with evening time.

Social History

Applicant's Name: _____

Please address the following items in the space provided. Use the back of this page if more space is required.

Place of Birth (City and State) _____

Religion _____ Education Level _____

Number of years in Alaska _____ Place of longest residence: _____

Past occupations _____

_____

No. of Marriages: _____ Number of children/names _____

_____

No. of siblings/names _____

_____

Reason for seeking assisted living _____

_____

_____

Present living situation _____

Issues of discussion that might create anxiety, depression, fear, or anger._____

_____

Current interests and hobbies _____

_____

Aspirations and goals _____

_____

Strengths and weaknesses_____

_____

Financial Information

Information relating to your finances is confidential and will not be shared with outside sources. This information is used strictly to determine your ability to pay McKinley Care ALH for services provided to you along with any other charges as stated in the Resident Services Contract. If you are unsure as to the dollar amount for each section, you may enter an approximation of said amount.

Current Monthly Income

Social Security $ _____

Supplemental Security $ _____

Retirement/Pensions $ _____

AK Senior Benefits $ _____

Other Source of Income $ _____

BANKING INFORMATION

1. Name of Bank _____

   Balance: _____

   Balance _____

2. Name of Bank _____

   Balance: _____

   Balance _____

Stocks/Bonds/Certificates of Deposit

Name _____Company _____

Number of Shares _____ Value $ _____

Other: _____ Value $ _____

Real Estate – Legal Description

1 Lot and Block Value $ _____ Mortgage Amount $ _____

2 Lot and Block Value $ _____ Mortgage Amount $_____

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

McKinley Care ALH
337 E 4th Ave Unit B
Anchorage AK 99501
Phone: (907) 268-6576
Fax: (907) 802-4374

Authorization to disclose the health information of:		Phone Number:
Name:	Date of Birth:	Social Security Number:
Current Address: City: State: Zip:		
This authorization is to disclose information to:		Phone Number: **(907) 268-6576**
Name: **McKinley Care ALH**	Receive by: ___ Mail or Pick-up ____ or Fax __**X**__ **(907) 802-4374**	
Address: City: State: Zip: **337 E 4th Ave Unit B Anchorage Alaska 99501**		
The purpose of this Disclosure is: ☐ **My Personal Use** ☐ **Other:**		
I hereby request: ☐ **To Review** ☐ **To Copy** For the date range of ____/___/____ to _____/_____/_____ or Or pertaining to:_____		
Please send the information as indicated below:		
☐ Diagnosis/Procedure	☐ Discharge Summary	
☐ Diagnostic Test Reports-Lab/Radiology	☐ Most Recent History	
☐ Emergency Department Visits	☐ X-Ray Report	
☐ Other: _____		
Term: I understand this authorization is specifically for information created from services provided before my date of signature. Information related to services provided after my date of signature will require an updated authorization. This authorization will expire (insert date or event): _____. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.		

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Resident Services/Administration department(s). I understand that the revocation will not apply to information that has already been released in response to this authorization.
I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
I understand that the information in my file may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

Signature of Resident or legal Representative:	**Date:**
If signed by legal Representative, Relationship to Patient	**Date Sent:**

337 E 4th Ave Unit B
Anchorage, AK 99501
Tel: (907) 268-6576
Fax: (907) 802-4374

PRIMARY PHYSICIAN'S REPORT
(to be completed by physician)

RESIDENT INFORMATION

Name: _____ DOB _____

Date of: Flu Shot _____ Pneumovax_____

ALLERGY(s) _____

OTC MEDICATION THIS INDVIDUAL MAY TAKE AS NEEDED
(Please initial all that apply)

Medication	Initial	Medication	Initial	Medication	Initial
Acetaminophen		Cough Syrup (plain)		Antidiarrheals	
Aspirin		Decongestants		Stool Softeners	
Antihistamines		Antacids		Laxatives	
OTC NSAIDs		Other:		Other:	

Order: All medications as ordered by the physician and taught by the McKinley Care Registered Nurse and may be administered by Assisted Living Home staff.

_____
Primary Diagnosis

_____
Physician's Signature **Date**

_____
Print Physician's Name **Telephone Number**

_____
Name of Other Health Care Professional Preparing Form (if other than Physician)