GRANDCARE
ASSISTED LIVING SERVICES

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Application Form

Full Name: _____ Gender: _____ DOB: _____

Medi-Cal or SS#: _____ Medicare # (If available): _____

Total Monthly Income: $_____ Income Type(s): ☐ SS ☐ SSD ☐ SSI ☐ Other _____

Marital Status: _____ Applicant's Phone #: _____ Email: _____

Other Medi-Cal / Medicare services being received? _____Days/Hours: _____

Does applicant need interpreter? ☐ Yes ☐ No Applicant's preferred language? _____

Applicant's current residence is at: ☐ Home ☐ B&C ☐ Assisted Living ☐ Nursing Home ☐ Hospital

Address of current residence: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ County: _____

Name of Facility (If applies): _____

How did you hear about **Grandcare Assisted Living Services** and the **ALW Program**? Check all that apply:

☐Medi-Cal Website ☐Placement Agency ☐Assisted living Facility ☐Friend/Family

☐Social Worker ☐Marketing Group ☐Skilled Nursing Facility ☐Other

Name of facility, Agency or Person who referred you: _____

Family/Contact 1: _____ Phone number: _____ Relationship_____

Email: _____ Other Phone Number: _____

Family/Contact 2: _____ Phone number: _____ Relationship_____

Email: _____ Other Phone Number: _____

Other Contact Notes: _____

What **County** are you looking to reside in? (Please keep in mind that we do not service all waiver counties)

☐ Los Angeles ☐ San Bernardino ☐ Riverside ☐ Orange ☐ San Diego ☐ Other

In what City or Area are you looking for placement: _____

List three facilities that that are options for placement where you would like to reside if any: (Optional)

Facility (1st): _____Contact: _____Phone: _____

Facility (2nd): _____Contact: _____Phone: _____

Facility (3rd): _____Contact: _____Phone: _____

To the best of your ability identify the applicant's cognitive status by checking the options that apply below:

☐ Lucid ☐ Mild Cognitive Impairment ☐ Alzheimer's ☐ Bipolar ☐ Schizophrenia ☐ TBI ☐ Other

Does the applicant have a legal representative for Advance Health Care Directives? ☐ Yes ☐ No

ALW program offers amenities as an enrollment benefit, select the amenities that would best fit your needs?

☐ Private Room ☐ Shared Room | ☐ With Microwave ☐ No Microwave | ☐ With Fridge ☐ No Fridge

1. Is the applicant on Hospice? ☐ Yes ☐ No If Yes, is it being covered by Medi-Cal? ☐ Yes ☐ No

2. Is the applicant receiving Home Health or Physical Therapy services? ☐ Yes ☐ No

3. Has the applicant been diagnosed with Dementia/Alzheimer's disease? ☐ Yes ☐ No

4. Does the applicant have a history of verbally abusive or combative behavior? ☐ Yes ☐ No
If yes, is it related to Dementia/Alzheimer? ☐ Yes ☐ No
Briefly describe behavior: _____
_____

5. Does the applicant suffer from any of the following conditions (check all that apply)?

☐ Shortness of breath with activity	☐ Vertigo	☐ Wandering behavior
☐ Shortness of breath requiring oxygen	☐ Dizziness	☐ Impaired judgment
☐ Loss of balance	☐ Forgetfulness	☐ Difficulty remembering

6. Does the applicant have any abrasions, rashes, or itches? ☐ Yes ☐ No
If yes, what treatment is being provided: _____
_____

7. Does the applicant have any open sores, skin tears, cuts or lesions? ☐ Yes ☐ No
If yes, what treatment is being provided: _____
_____

8. Does the applicant need an assistive device to ambulate? ☐ Yes ☐ No
If yes, check all that apply:

☐ Cane ☐ Walker ☐ Wheelchair (W/C) ☐ Motorized W/C ☐ Safety rails on walls

9. Does the applicant need assistance with ambulating? ☐ Yes ☐ No
If yes, explain how (ex: he/she need to be pushed in w/c): _____
_____

10. Does the applicant need help getting out of bed and into a chair? (transferring) ☐ Yes ☐ No
If yes, describe assistance provided: _____
_____

11. Does the applicant need help turning or moving in bed? ☐ Yes ☐ No

12. Does the applicant need assistance with toileting? (Transferring, cleaning) ☐ Yes ☐ No
If yes, describe assistance provided and how often: _____
_____

13. Does the applicant wear adult briefs, diaper, or pads? ☐ Yes ☐ No
If yes, describe why: _____
_____

14. Does the applicant need help changing adult briefs, diaper, or pads? ☐ Yes ☐ No
If yes, describe assistance provided and how often: _____
_____

15. Does the applicant need help getting dressed? ☐ Yes ☐ No
If yes, describe assistance provided and how often: _____
_____

16. Does the applicant need help with bathing or taking a shower? (transferring) ☐ Yes ☐ No
If yes, describe assistance provided and how often equipment used if any: _____
_____

17. How many medications is the applicant currently taking: _____ (make sure to provide a list of medication)

18. Does the applicant need help with medication management/administration? ☐ Yes ☐ No
If yes, please answer the following questions?

- Does the applicant know what the medications are taken for? ☐ Yes ☐ No
- Does the applicant know how to take the medications? ☐ Yes ☐ No
- Does the applicant know how often to take the medications? ☐ Yes ☐ No

19. Is the client Diabetic? ☐ Yes ☐ No
If yes, please answer the following questions?

- Does the applicant know how to monitor his/her blood sugar levels? ☐ Yes ☐ No
- Does the applicant take insulin? ☐ Yes ☐ No
- Does the applicant receive injections? ☐ Yes ☐ No
- Is the applicant able to administer his/her own injections? ☐ Yes ☐ No

20. Does client have a special diet that needs to be followed? ☐ Yes ☐ No
If yes, describe the special diet: _____
_____

21. Does the applicant need help eating? (Example: feeding him/her) ☐ Yes ☐ No
If yes, describe assistance provided and how often: _____
_____

22. Does the applicant need help with transportation? ☐ Yes ☐ No
If yes, check all that apply: ☐ Doctors' appointments ☐ Shopping ☐ Senior Centers ☐ Other
If other was checked, briefly describe: _____
On a monthly average about how many times would transportation be needed: _____

Thank you for taking the time to complete this questionnaire. This questionnaire will be reviewed to determine the candidate's pre-eligibility for the Assisted Living Waiver Program. If the candidate meets the criteria for the program, our registered nurse will call to set up an appointment to conduct a face-to-face assessment.

By signing below, the Applicant or Legal Representative acknowledges that:

- ✓ He/ She has a general understanding of the process for participating for the "Assisted Living Waiver Program"
- ✓ He/ She is interested in participating in the "Assisted Living Waiver Program"
- ✓ He/ She is requesting that an assessment be conducted by Grandcare Assisted Living Services to determine eligibility for the "Assisted Living Waiver Program"
- ✓ He/ She authorize the release of medical records to Grandcare Assisted Living Services evaluating staff.

Applicant's Name (Print)	Signature	Date
Legal Representative's Name (Print)	Signature	Date

Please make sure that all requested documents in the "Instructions Sheet" are included when submitting this application. An assessment will <u>NOT</u> be scheduled until all the documents are received. The date received on our database will be identified as the date that we receive a complete application packet.