Part I: Personal Information

First Name

Last Name

UCI #

Address

City, Zip

Phone

Height Weight

Eye Color Age

Date of Birth

Sex Male Female Other

Are you conserved? ☐ Yes ☐ No

Responsible Party

First Name

Last Name

Address

City, Zip

Email

Phone

Relationship

Emergency Contacts

First Name

Last Name

Address

City, Zip

Email

Phone

Relationship

Contact # 2

First Name

Last Name

Address

City, Zip

Email

Phone

Relationship

Inland Regional Center CSC

First Name

Last Name

Email

Part II: Legal Status

Is there any one person authorized to make decisions under a power of attorney or a legal guardian? ☐ Yes ☐ No

If YES, who/relationship: ____

Do you have a living will, or advance directive? ☐ Yes ☐ No

*If YES to either question, we will need a copy for our records.

Part III: Referral

How did you hear about Martha Helen Ozan Palmer Foundation (MHOP)?

Reason(s) for wanting to attend MHOP?

If determined eligible, how many days a week do you plan to attend the program?

☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

Part IV: Living Arrangements and Transportation

Living Arrangements ☐ Spouse ☐ Child ☐ Other:

Type of Dwelling ☐ House ☐ Apartment ☐ Other

Lives with Someone? ☐ Yes ☐ No **Lives Alone?** ☐ Yes ☐ No

Present Address:

Does the applicant carry a house key? ☐ Yes ☐ No

If yes, can the applicant be left at home alone? ☐ Yes ☐ No

Part V: Family and Social History

Birthplace

Father's Name **Mother's Name**

Name(s) of living siblings:

Name(s) of deceased siblings:

Name(s) of living children, if any:

Name(s) of deceased children, if any:

Highest Grade Level Completed

Are you a Veteran? ☐ Yes ☐ No **If yes, what branch?**

What is/was your main occupation?

Spouse of a Veteran? ☐ Yes ☐ No **Child of a Veteran?** ☐ Yes ☐ No

What was your worst job?

Checkmark any activities of potential interest.

☐ Arts & Crafts	☐ BINGO	☐ Card Games
☐ Physical Fitness	☐ Music/Choir	☐ Table/Board Games
☐ Sports	☐ Pet Therapy	☐ Socializing
☐ Plant Care/Gardening	☐ Reading Newspaper/Magazines	☐ Other:
☐ Sensory/Mental Stimulation	☐ Bible Study	

Is the applicant comfortable in the company of non-family members? ☐ Yes ☐ No

What are their best skills/qualities?

Part VI: Medical Information and Health History

List all the Applicants Diagnosis'

Primary Care Provider

Phone **Address**

Are there any other Doctors we should know about? ☐ Yes ☐ No

Doctor

Phone **Address**

Doctor

Phone **Address**

Preferred Hospital

Preferred Medical Transport Company

How would you or applicant rate their health? ☐ Good ☐ Fair ☐ Poor

Current Medical Concerns

Prior Medical Concerns

Have you/applicant ever been hospitalized? ☐ Yes ☐ No

Reason

Date **Location**

Reason

Date **Location**

Does the applicant have diabetes? ☐ Yes ☐ No

If yes, how is it managed? ☐ Oral Meds ☐ Insulin ☐ Diet

Does the applicant have seizures? ☐ Yes ☐ No

If yes, explain

Is the applicant allergic to any medications? ☐ Yes ☐ No

If yes, explain

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Is the applicant allergic to any environmental allergens? ☐ Yes ☐ No

If yes, explain

Can the applicant self-administer medications? ☐ Yes ☐ No

LIST OF MEDICATIONS (INCLUDE NON-PRESCRIBED)

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>

Part VII: Medical Information and Health History

What other community agencies (Home health/social service) do you currently or have used?

Agency	**Reason**

Does the applicant have a care manager? ☐ Yes ☐ No

If yes, name and phone number: ______________________

Are there any other caregivers besides the responsible party listed in Part I? ☐ Yes ☐ No

If yes, list: ______________________

Limitations, problems, or restraints on primary caregiver? ☐ Yes ☐ No

If yes, explain: ______________________

What is the extent of the burden on the caregiver (s)?

Does the caregiver feel the need for support? ☐ Yes ☐ No

If yes, explain: ______________________

Part VIII: Medical Information and Health History

Levels of Assistance – Please use the guide below and check where appropriate.

0 = Independent – Completes task independently.
1 = Minimum Assistance – Occasional Assistance or Supervision may be necessary.
2 = Moderate Assistance – Assistance or Supervision is always needed.
3 = Maximum Assistance – Totally dependent on others.

Activity	**0**	**1**	**2**	**3**	**Primary Source**	**Comment**
Mobility	☐	☐	☐	☐		
Transferring	☐	☐	☐	☐		
Bathing	☐	☐	☐	☐		
Grooming	☐	☐	☐	☐		
Hygiene	☐	☐	☐	☐		
Eating	☐	☐	☐	☐		
Toileting	☐	☐	☐	☐		
Meal Prep.	☐	☐	☐	☐		
Laundry	☐	☐	☐	☐		
Shopping	☐	☐	☐	☐		
Light Housework	☐	☐	☐	☐		
Home Maintenance	☐	☐	☐	☐		
Telephone	☐	☐	☐	☐		
Financial Mngmt.	☐	☐	☐	☐		
Transportation	☐	☐	☐	☐		

Medical Devices Used

- ☐ Walker
- ☐ Cane
- ☐ Wheelchair
- ☐ Oxygen
- ☐ Hearing Aid
- ☐ Glasses
- ☐ Dentures
- ☐ Feeding Tube
- ☐ Hospital Bed
- ☐ Ostomy
- ☐ Catheter

Notes about devices above

Part IX: Special Diet/Nutrition

Special Diet? ☐ Yes ☐ No **If yes, explain:**

Allergies? ☐ Yes ☐ No **If yes, explain:**

How is their appetite? ☐ Good ☐ Fair ☐ Poor

How many meals per day? ☐ 1 ☐ 2 ☐ 3 **Snacks:** Enter Amt.

Chewing or swallowing problems? ☐ Yes ☐ No

If yes, please explain

Troublesome foods? ☐ Yes ☐ No **If yes, explain:**

Special Instructions at Mealtime? ☐ Yes ☐ No **If yes, explain:**

Part X: Cognitive/Behavioral Status

Is the applicant oriented… Person? ☐ Yes ☐ No **Place?** ☐ Yes ☐No **Time?** ☐ Yes ☐No

How is the applicants recent (short-term) memory? ☐ Good ☐ Fair ☐ Poor

How is the applicants distant (long-term) memory? ☐ Good ☐ Fair ☐ Poor

What are the applicant's favorite vacation or memory?

Is the applicant able to follow and understand written directions? ☐ Yes ☐ No

Is the applicant aware of dangers, risks, and consequences? ☐ Yes ☐ No

Is the applicant able to follow and understand written directions? ☐ Yes ☐ No

Check any behaviors the applicant has experienced:

☐ Depression ☐ Anxiety ☐ Paranoid ☐ Suicidal Thoughts
☐ Aggressive ☐ Agitated ☐ Withdrawn

Is the applicant receiving any mental health treatment? ☐ Yes ☐ No

Explain:

Is the applicant experiencing any CURRENT emotional problems or related behaviors, such as wandering and/or sleeplessness? ☐ Yes ☐ No

Explain:

Part XI: Tell Us More About the Applicant

What is one thing you with people knew about the applicant or yourself?

Are there any additional notes or concerns not listed you wish to provide?

Part XII: Applicant Acknowledgement

I hereby certify that the information on this screening form is true and correct to the best of my knowledge.

Applicant Name **Relationship** **Date**

Authorized Representative Signature **Relationship** **Date**

TO BE COMPLETED BY MHOP FOUNDATION

Does the applicant meet the criteria for admission? ☐ Yes ☐ No

If NO, has the applicant received written notice within 30 days of intake screening? ☐ Yes ☐ No

Authorized Signature **Date**