HIGH HOPES
APPLICATION FOR ADMISSION

HIGH HOPES HEAD INJURY PROGRAM is a nationally recognized, one-of-a-kind program dedicated to helping brain-injured individuals recover their lives. High Hopes is the first program of its kind in the country and we are looking forward to helping you and your family. The goal of HIGH HOPES is to provide comprehensive rehabilitation services for the head injured leading to maximum independence for the individual within the community at a low cost. We provide adult services to those who meet the entrance criteria.

SERVICES: **HIGH HOPES HEAD INJURY PROGRAM** provides the best day treatment program possible at an affordable cost. These include Occupational Therapy, Physical Therapy, and Speech Therapy. Physical Programs, Re-Socialization, Cognitive Retraining, Independent Living Skills Development, Pre-Vocational Training, and Computer Assisted Instruction. High Hopes's goal is to provide the best program at the lowest cost possible.

TAX STATUS: **HIGH HOPES** operates as a non-profit organization in California, under Internal Revenue Service Code 501-C (3). All donations are, therefore, tax-deductible as allowed by law.

FINANCE: **HIGH HOPES** relies on fees for services, and the generosity of the community for its support. Contributions, bequests, gifts, grants, and fundraisers provide scholarship assistance for those who cannot afford services.

CREDENTIALS: **HIGH HOPES** is licensed by the State of California, Department of Social Services as an Adult Treatment Facility. We are vendored by the Regional Center of Orange County. We have a highly qualified professional staff with many years of service and have provided successful outcomes for hundreds of brain-injured individuals.

FACILITIES: **HIGH HOPES** maintains a 12,000-square-foot facility in Tustin. We utilize local resources such as the community pool, and the local 24-Hour Fitness Center. Our facility is located at 2953 Edinger Avenue, Tustin, CA 92780.

FOR FURTHER INFORMATION ON HIGH HOPES
PLEASE CALL (949) 733-0044

Application Checklist

1. _____ 3 Page Applicant Information (Signatures on Last Page)
2. _____ Emergency Data Sheet
3. _____ Fee Information and Agreement
4. _____ Physician's Release and Report for Admission (Filled out & Signed by Physician)
5. _____ Records Release Form (Send to Doctors, not to High Hopes in order to get medical records)
6. _____ 2 Page Request for Scholarship Funds (Optional)
7. _____ Personal Rights Adult Community Care Facilities (State Form)
8. _____ Consent For Emergency Medical Treatment (State Form)
9. _____ Physician's Report For Residential Care Facilities For the Elderly (State Form; Filled out by Physician)

APPLICANT INFORMATION

Name of Prospective Student_____

The following application is to be completed by the prospective student. If the prospective student is unable to complete the application, please explain why?

_____

Name of Person Completing the Application_____

Relationship to Prospective Student_____

PROSPECTIVE STUDENT'S INFORMATION

Name_____Date of Birth_____Age_____

Diagnosis: Traumatic Brain Injury ☐ Stroke ☐ Multiple Sclerosis ☐ Other ☐

Social Security Number_____

Home Phone_____Cell_____**Email**_____

Address of Residence_____

City_____Zip_____

Residence is: (check one)

_____Group Home _____Care Facility _____ Lives with Family

____ Lives on their Own _____ Other_____

Name of group home or facility_____

What means of transportation will you use in getting to classes?

( ) Drive self ( ) Family/friend

( ) Walk ( ) Public Transportation ( ) Other_____

Have you ever been arrested for anything other than a misdemeanor? ( ) Yes ( ) No

If yes, what charge_____

When_____Disposition_____

Are you on probation? ( ) Yes ( ) No Have you ever been on probation? ( ) Yes ( ) No

If yes, date_____

Guardian's Name_____Relation_____

Address (if different from student)_____

City_____Zip_____Email_____

Home Phone:_____Work_____Cell_____

CURRENT MEDICAL DATA

Present Physician_____

Address_____Phone_____

Present Medical Problems_____

_____

Do you suffer from

( ) Hearing impairment, if so what degree_____

( ) Visual impairment, if so what degree_____

( ) Paralysis, if so what degree_____

( ) Incontinence

Have you ever tested positive for the HIV (AIDS) virus?_____
Date Tested_____( ) Positive ( ) Negative
Do you use: ( ) Wheelchair ( ) Quadcane ( ) Cane ( ) Walker
Can you use the restroom facilities unaided? ( ) Yes ( ) No
Have you ever had a seizure? ( ) Yes ( ) No
If yes, give the date of the last seizure_____How many in the last 12 months_____
Allergies:_____
Have you ever been treated for alcoholism or drug abuse?( ) Yes ( ) No
If yes, when were you treated?_____What treatment?_____

MEDICAL HISTORY

Date of trauma_____Age at time of trauma?_____
If in a coma, how long?_____
Please describe the accident, injury, or cause of trauma_____

_____
_____

MEDICAL CARE RECEIVED AFTER TRAUMA

Hospital City Physician Dates

_____
_____
_____

CARE FOLLOWING HOSPITAL (Acute Care etc.)

_____
_____
_____

PSYCHIATRIC CARE (Counseling, Psychotherapy, etc.)
Include pre and post-trauma care

Site City Contact Dates

_____
_____
_____

EDUCATIONAL HISTORY PRIOR TO TRAUMA

High School Attended_____Date of Graduation_____
Circle last grade completed 9 10 11 12 13 14 AA BA MA Ph.D.
Education after High School_____

_____

EDUCATION/REHABILITATION SINCE TRAUMA

Site City Contact Dates

_____
_____
_____

OTHER SERVICES

Are you presently the client of another agency? ( ) Yes ( ) No
If yes, what agency?_____
Address_____Phone_____
Counselor/Contact_____

WORK HISTORY PRIOR TO TRAUMA

Employer City Position Dates

_____
_____
_____

Are you currently working? ( ) Yes ( ) No
If yes, what type of position?_____Employer_____
How long have you held this position?_____

I hereby declare the statements and answers in this application are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application, and I hereby release from all liability and person(s) or organization(s) furnishing such information. I understand that falsification, misrepresentation, or omission of the facts is reasonable cause for rejection of the application, and removal of my name from consideration from the HIGH HOPES HEAD INJURY PROGRAM.

_____ _____
Date Applicant's Signature

_____ _____
Date Signature of Parent or Legal Guardian or Caretaker

AUTHORIZATIONS

I grant my approval for_____to participate in High Hopes programs and activities at 2953 Edinger Ave., Tustin, CA 92780 and at locations away from the facility in activities supervised and planned by the High Hopes staff. I release High Hopes Head Injury Program from any liability from my son/daughter/spouse/self-participating in said programs. I understand that High Hopes DOES NOT provide health and medical insurance for the participants. Consent is hereby given to High Hopes Instructors and Supervisors to give or seek medical aid as required in the case of an emergency.

_____ _____
Signature of Applicant Date Guardian/Caretaker/Parent Date

I authorize High Hopes to take photographs and films of the above-named individual for his/her chart, professional education publications, study, and various publications used inside or outside High Hopes.I give permission to use his/her/my name in all such publications.

_____ _____
Signature of Applicant Date Guardian/Caretaker/Parent Date

Date Completed_____

HIGH HOPES HEAD INJURY PROGRAM

EMERGNECY DATA SHEET

Student Name_____Date of Birth_____
Phone (____)_____**Email**_____
Address_____
Street City Zip Code

(1) **Legal Guardian/Person To Notify in an Emergency**_____
___Relation_____Cell (___)_____Home (_)_____
Work (___)_____Email_____

(2) **Legal Guardian/Person to Notify in an Emergency** _____
Relation_____Cell (___)_____Home (___)_____
Work (___)_____Email_____

Person to Contact for Attendance/Payment Purposes_____Relation_____
Cell (___)_____Home (___)_____Work (___)_____
Email_____

Medical Information

Date of Trama_____

Medications: Type_____Mg. Dosage_____Times per day_____
Type_____Mg. Dosage_____Times per day_____
Type_____Mg. Dosage_____Times per day_____
Type_____Mg. Dosage_____Times per day_____

Allergies_____
_____

Seizures_____/_____Type_____Date of last seizure_____
Yes No

Primary Physician_____Phone (___)_____

Authorization for MEDICAL TREATMENT: I hereby authorize High Hopes Head Injury Program to make emergency first aid treatment as High Hopes may feel is indicated. Furthermore, I request High Hopes to take the above-named individual to a hospital if further treatment is required. I understand that payment for emergency medical treatment will be the responsibility of the individual and/or the legal guardian. I also understand that the above-named person is participating in High Hopes programs and activities at his/her own risk.

_____ _____
Date Applicant's Signature

_____ _____
Date Signature of Parent or Legal Guardian or Caretaker

FEE INFORMATION & AGREEMENT

HIGH HOPES HEAD INJURY PROGRAM was the first head injury program in the country. Our program fees are designed to meet the costs of providing services. When compared with other rehab programs, our fees are by far less, since our program is non-profit. Other programs are charging a national average of $1,500.00 per day or $35,000.00 per month. The results of our program have been outstanding. Our goal is to provide the best program possible at the lowest cost.

WHEN APPLYING: A $50.00 application fee must accompany your application.

WHEN STARTING: First-month tuition is due on the first day of class. _____(Initial)

PROGRAM FEES: Full-time student fee is $3,500.00 per month. Part-Time Fee $2,000.00 per month.

SCHOLARSHIP FUNDS: Community support through donations, fund-raisers, and grants. Scholarships are designed to offset some of the cost of services for those who cannot afford the program fees. Applications are reviewed annually. If applying for scholarship assistance, please return the enclosed scholarship form as soon as possible. **All scholarship recipients MUST pay their fee on time** _____(Initial)

RECEIVE: High Hopes provides full-service day treatment. Services include physical therapy, speech therapy, occupational therapy, cognitive retraining, vocational services, and advanced robotics.

INSURANCE & REGIONAL CENTERS: Insurance companies and Regional Centers may cover all or part of our fees. Families/significant others should follow up with your insurance company or Regional Center to see if our fees are covered.

MONTHLY FEES: Tuition statements are mailed out at the beginning of the month. **Tuition fees are not determined by attendance**. **Tuition fees are non-refundable and non-transferable. There is no tuition credit for absences.**

- Tuition is due in advance by the 1st of each month and is payable to High Hopes by check, money order, or credit card. Payment not received by the 15th will be charged a $25 late fee. _____(Initial)
- A $25.00 fee is charged for checks returned from the bank for insufficient funds (NSF).
- Once an account receives ONE (1) insufficient funds (NSF) check, all future tuition payments must be made by credit cards, money order, or cashier's check a month in advance.
- **All scholarship recipients must keep their fees up to date or they will be dropped from the scholarship program, and will be charged at the regular rates.** _____(Initial)
- To terminate service, a written notice has to be submitted 1 month (30 days) in advance, so that the spot can be filled by students who are on the waiting list. _____(Initial)

I have read the above fee information and I do understand my responsibility to meet my obligation in order to receive services through High Hopes Head Injury Program.

_____	_____
Date	Applicant's Signature

_____	_____	_____
Date	Responsible Party Name (PLEASE PRINT)	Responsible Party Signature

PHYSICIAN'S RELEASE & REPORT FOR ADDMISSION

Note to Physician: This is part of your patient's application for admission to High Hopes Head Injury Program, Day Treatment Program. This facility provides the personal care and supervision normally provided by a relative or a member of the family. A current health report is required on each person in the facility.

Name:_____Date of Birth:_____Age: _____
Height:_____Weight:_____ Blood Pressure_____

	Normal? (Circle One)	Comments (List any Impairments)
General Health	**Yes No**	
Ears	**Yes No**	
Eyes	**Yes No**	
Nose/Mouth/Throat	**Yes No**	
Heart	**Yes No**	
Mental Health	**Yes No**	

TB Exam Active or Quiescent_____Inactive or None_____
Any Contagious or Infectious Diseases?_____

Medications: Type_____Mg. Dosage_____Times per day_____
Type_____Mg. Dosage_____Times per day_____
Type_____Mg. Dosage_____Times per day_____

Allergies_____
Special Diet:_____
Seizures_____/_____Type_____Date of last seizure_____
Yes No

_____ (name of applicant) was given a routine physical examination for the purpose of participating in the HIGH HOPES special education program. I certify that he/she may actively participate in the Adapted Physical Educational/Therapeutic Recreation programs designed to enhance sensory motor and physical abilities as well as passive and active leisure time activities.

Limitations or Restrictions For Activities and Programs:_____
_____

_____ _____
Physician's Name (print) **Physician's Signature**

_____ _____
Address **Phone Number**

HIGH HOPES HEAD INJURY PROGRAM
RECORDS RELEASE FORM

Note to Applicant: This form may be used to ask your doctor/therapist to send your medical records to High Hopes. If you decided not to use this form, High Hopes still needs a copy of your medical records.
Instructions: Fill in the name and addresses of the doctor, therapist or hospital at the top of the page. Sign your name at the bottom of the form and mail the form to your doctor/therapist. **DO NOT MAIL THIS FORM TO HIGH HOPES!** When your doctor receives this form he/she will send us the records you have requested.

To:_____
(Contact Person)

_____
(Agency Name)

_____
(Street Name and Number)

_____
(City) (State) (Zip Code)

RE:_____ Date of Birth_____
(Patient's Name)

I hereby request and authorize you to release to High Hopes Head Injury Program any medical, psychological, social, vocational, and/or educational testing information you have, or may receive, pertaining to me. I am assured by High Hopes that such information will remain confidential and be used on my behalf towards the effectiveness of my individual program.

_____ _____
Date Signature of Student

_____ _____
Date Signature of Parent/Legal Guardian/Caretaker

Please mail records to:
(Prefer records on a CD but will accept a paper copy)

High Hopes Head Injury Program
Attn: Tracey Desmond 2953
Edinger Ave. Tustin, CA 92780

REQUEST FOR STUDENT SCHOLARSHIP FUNDS

High Hopes Head Injury Program has established a special student scholarship fund to assist students and families who are unable to pay the program fee in full. It is only by contributions from individuals, grants, and companies that we are able to provide this assistance.

Scholarships are reviewed yearly and possible adjustments may occur depending on the need for assistance and the availability of funds. There are also specific responsibilities that are mandatory in order to remain eligible for funding. Failure to comply with the mandatory responsibilities will result in cancellation of scholarship funding. These mandatory responsibilities include:

Please complete the following:

I,_____request a monthly contribution from the Student Scholarship Fund in order to reduce my individual program fee. I understand funding my request for assistance is dependent on my needs and availability of Scholarship Funds. My scholarship assistance will not exceed 50% of my monthly fee. I am requesting the following amount of Scholarship assistance each month $_____to offset my monthly fee.

Please Provide general documentation to support the following requested information
(Tax returns, SSI, SSDI, copies of check stubs, etc.)

Financial Information of Prospective Student:

Monthly Total Income:_____

Sources of Income and Amount:

Employment Income:_____
Settlement Income:_____
SSI Income:_____
SSDI Income:_____
Other Income_____

Family Support Information: (The following information is requested if the family is providing financial support for the student)

Does the Student live with the family? _____Yes_____No
Number of Dependents _____

Current Financial Support includes: (Please Check or List Items)

Housing _____
Food _____
Transportation _____
Therapy Services _____
In Home Support _____
Other Expenses _____
_____

Yearly Gross: _____

Thank you for completing this form. All information will remain confidential.

PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

EXPLANATION: The California Code of Regulations, Title 22 requires that any person admitted to a facility must be advised of his/her personal rights. Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of persons admitted to facilities and the facility owners who are required to post these rights.

This form describes the personal rights to be afforded each person admitted to an adult community care facility. The form also provides the complaint procedures for the client and representative/conservator. The facility staff or client representative must communicate these rights in a manner appropriate for client's ability.

This form is to be reviewed, completed and signed by each client and/or each representative/conservator upon admission to the facility. The client and/or representative/conservator also has the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the client's file which is maintained by the facility.

TO: CLIENT OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: At the time of admission I have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22.

(PRINT THE NAME OF THE FACILITY) (PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CLIENT)

(SIGNATURE OF THE CLIENT) (DATE)

(SIGNATURE OF THE REPRESENTATIVE/CONSERVATOR)

(TITLE OF THE REPRESENTATIVE/CONSERVATOR) (DATE)

THE CLIENT AND/OR THE REPRESENTATIVE/CONSERVATOR HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS. THIS AGENCY IS:

NAME

ADDRESS

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
		( )

PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

Each client shall have rights, which include, but are not limited to the following:

(1) A right to be treated with dignity, to have privacy and to be given humane care.

(2) A right to have safe, healthful and comfortable accommodations, including furnishings and equipment to meet your needs.

(3) A right to be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature. To be free from restraining devices, neglect or excessive medication.

(4) A right to be informed by the licensee of provisions in the law regarding complaints, including the address and telephone number of the licensing agency, and of information regarding confidentiality.

(5) A right to attend religious services and activities . Participation in religious services and other religious functions shall be on a completely voluntary basis.

(6) A right to leave or depart the facility at any time, and to not be locked into any room or building, day or night. This does not prohibit the development of house rules, such as the locking exterior doors or windows, for the protection of the consumer.

(7) A right to visit a facility with a relative or authorized representative prior to admission.

(8) A right to have communications between the facility and your relatives or authorized representative answered promptly and completely, including any changes to the needs and services plan or individual program plan.

(9) A right to be informed of the facility's policy concerning family visits. This policy shall encourage regular family involvement and provide ample opportunities for family participation in activities at the facility.

(10) A right to have visitors, including advocacy representatives, visit privately during waking hours provided the visits do not infringe upon the rights of other consumers.

(11) A right to possess and control your own cash resources.

(12) A right to wear your own clothes, to possess and use your own personal items, including your own toilet articles.

(13) A right to have access to individual storage space for your private use.

(14) A right to have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of the telephone in emergencies.

(15) A right to promptly receive your unopened mail.

(16) A right to receive assistance in exercising your right to vote.

(17) A right to receive or reject medical care or health-related services, except for those whom legal authority has been established.

(18) A right to move from a facility in accordance with the terms of the admission agreement.

Reference:

California Code of Regulations, Title 22, Division 6 - General Licensing Regulations, Section 80072; Section 81072, Social Rehabilitation Facilities; Section 85072, Adult Residential Facilities; Section 87872, Residential Care Facilities for the Chronically Ill.

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Adult and Elderly Residential Facilities

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

_____ TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER WHATEVER
NAME

CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE INDIVIDUAL NAMED ABOVE.

CLIENT HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

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

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)

I. FACILITY INFORMATION (To be completed by the licensee/designee)

1. NAME OF FACILITY		2. TELEPHONE ( )
3. ADDRESS	CITY	ZIP CODE

4. LICENSEE'S NAME	5. TELEPHONE ( )	6. FACILITY LICENSE NUMBER

II. RESIDENT/PATIENT INFORMATION (To be completed by the resident/resident's responsible person)

1. NAME	2. BIRTH DATE	3. AGE

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(To be completed by resident/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above.

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE

2. ADDRESS	3. DATE

IV. PATIENT'S DIAGNOSIS (To be completed by the physician)

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered.
(Please attach separate pages if needed.)

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE

6. **TUBERCULOSIS (TB) TEST**

a. Date TB Test Given	b. Date TB Test Read	c. Type of TB Test	d. Please Check if TB Test is: ☐ Negative ☐ Positive

e. Results: mm_____ f. Action Taken (if positive): _____

_____

g. Chest X-ray Results: _____

h. Please Check One of the Following:

☐ Active TB Disease ☐ Latent TB Infection ☐ No Evidence of TB Infection or Disease

7. PRIMARY DIAGNOSIS:

a. Treatment/medication (type and dosage)/equipment:

b. Can the patient manage their own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

8. SECONDARY DIAGNOSIS(ES):

a. Treatment/medication (type and dosage)/equipment:

b. Can the patient manage their own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

☐ Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.

☐ Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgment, and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE:

a. Treatment/medication (type and dosage)/equipment:

b. Can the patient manage their own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

11. ALLERGIES:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

12. OTHER CONDITIONS:

a. Treatment/medication (type and dosage)/equipment:

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

13. PHYSICAL HEALTH STATUS	**YES**	**NO**	**ASSISTIVE DEVICE** (If applicable)	**EXPLAIN**
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Wears Prosthesis				
e. Special Diet				
f. Substance Abuse Problem				
g. Use of Alcohol				
h. Use of Cigarettes i.				
Bowel Impairment				
j. Bladder Impairment				
k. Motor Impairment/Paralysis				
l. Requires Continuous Bed Care				
m. History of Skin Condition or Breakdown				

14. MENTAL CONDITION		YES	NO	EXPLAIN
a. Confused/Disoriented				
b. Inappropriate Behavior				
c. Aggressive Behavior				
d. Wandering Behavior				
e. Sundowning Behavior				
f. Able to Follow Instructions				
g. Depressed				
h. Suicidal/Self-Abuse				
i. Able to Communicate Needs				
j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items				
k. Able to Leave Facility Unassisted				

15. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self			
b. Able to Dress/Groom Self			
c. Able to Feed Self			
d. Able to Care for Own Toileting Needs			
e. Able to Manage Own Cash Resources			

16. MEDICATION MANAGEMENT	YES	NO	EXPLAIN
a. Able to Administer Own Prescription Medications			
b. Able to Administer Own Injections			
c. Able to Perform Own Glucose Testing			
d. Able to Administer Own PRN Medications			
e. Able to Administer Own Oxygen			
f. Able to Store Own Medications			

17. AMBULATORY STATUS:

a. 1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:
☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and/or a person who depends upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of fire clearance, this means a person who requires assistance with turning or repositioning in bed.

b. If the resident is nonambulatory, this status is based upon:

☐ Physical Condition ☐ Mental Condition ☐ Both Physical and Mental Condition

c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery, or other cause:

☐ Illness: _____

☐ Recovery from Surgery: _____

☐ Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

d. If a resident is bedridden, how long is bedridden status expected to persist?

1. _____ (number of days)

2. _____ (estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)

3. If illness or recovery is permanent, please explain: _____

_____

_____

_____

e. Is resident receiving hospice care?

☐ No ☐ Yes If yes, specify the terminal illness: _____

18. PHYSICAL HEALTH STATUS: ☐ Good ☐ Fair ☐ Poor

19. COMMENTS:

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

21. TELEPHONE ( )	**22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT**
23. PHYSICIAN'S SIGNATURE	**24. DATE**