



Skilled Nursing Care

St. Joseph's Home

Utilization of Respite Care Services are pre-arranged and limited to one or more periods from five (5) to thirty (30) days not to exceed more than forty-two (42) days in any one (1) year.

An assessment of an applicant shall be completed prior to admission to gather basic information. A signed physician's history and physical examination must also be completed and provided to the nursing home prior to admission. This information can be up to one (1) year old if it is accompanied by a signed statement from the physician certifying that the condition(s) of the applicant have not changed. The nursing home will admit only under a physician's order. Assessment will include functional and cognitive status, psychosocial status, sensory or physical impairments, dental status, nutritional status and dietary needs, special treatments, medication and activities potential.

The social worker will arrange for a meeting with the applicant at the applicant's home or nursing home, the purpose being to determine whether the nursing home is capable of meeting the needs of the individual. The meeting is required before acceptance can be determined.

St. Joseph's Home

The Application Process

- 1) The completed application should be returned to the Social Service office, St. Joseph's Home. It is imperative that complete and accurate information be provided and if clarification of any questions is required, please call (315) 393-3780, Ext. 1014.
- 2) A physician's pre-admission physical form is required if the applicant resides in the community and will be forwarded to the identified family physician by our Social Worker. If the applicant is in the hospital or another nursing facility, all required information will be gathered by our Social Worker.
- 3) A PRI (patient review instrument) must be completed for applicants residing in the community. This assessment helps the nursing home in determining the level of care required. Our Social Worker will arrange to have this assessment done. If the applicant is private pay he/she will pay privately. Medicaid will pay the cost for those who qualify. This form requires updating if placement does not take place within ninety days.
- 4) If possible, information to be submitted with the application include:
 - Health Care Proxy
 - Do Not Resuscitate orders (DNR)
 - Living Will
 - Power of Attorney
 - Insurance cards
 - Social Security card
 - Medicare card
 - Medicaid card
 - Prescription drug plan card

We would be happy to make copies of this information for you.

- 5) A home visit from St. Joseph's staff is arranged as part of the admission process. The purpose of said visit is to evaluate the appropriateness of the recommended level of care and verify the information provided in the PRI. There is no cost to the application for this visit.
- 6) St. Joseph's Home now has a respite program, two (2) rooms, one (1) on each floor to accommodate short-stay admissions. The services are pre-arranged and limited to one or more periods from five (5) to thirty (30) days not to exceed more than 42 days in any one year. A stay of less than five (5) days may be approved on an exception basis.
- 7) Whenever possible, we recommend the applicant and/or family arrange to visit our home for a tour.



St. Joseph's Home

Skilled Nursing Care

Application for Admission to Respite Care

Name: _____ Telephone #: _____

Legal Address: _____

Date of Birth: _____

____ Male ____ Female

____ Married ____ Single ____ Widowed ____ Separated ____ Divorced

U.S. Citizen ____ Yes ____ No

Religion: _____

Occupation: _____

Personal Physician: _____

Spouse Name/Address: _____

Contact Person(s) in the event of an emergency:

1. Name: _____ 2. Name: _____

Address: _____ Address: _____

Relationship: _____ Relationship: _____

Telephone #: _____ Telephone #: _____

Advance Directives (Circle)

Health Care Proxy Yes No

Living Will Yes No

DNR Order Yes No

Body Donor Yes No

Organ Tissue Donor Yes No

Do you have a Power of Attorney Yes No

If yes, Name: _____

950 Linden Street . Ogdensburg, New York 13669

315-393-3780 . Fax: 315-393-3847

Web Site: www.stjh.org



Skilled Nursing Care

Page 2 _____

Insurance Coverage

Medicare #: _____

Social Security #: _____

Medicaid #: _____

County: _____

PDP (Prescription Drug Plan) #: _____

Anticipated Length of Stay: _____

Medications: _____

Funeral Arrangements

Name of Funeral Home: _____

Person Responsible for Arrangements: _____

Address: _____

Phone #: _____

Signature of Applicant

Date

ST. JOSEPH'S HOME
PRE-ADMISSION STUDY

NAME: _____

PRESENT LOCATION: HOME _____ HOSPITAL _____ OTHER _____

ADDRESS: _____

MARITAL INFORMATION:

SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

SPOUSE: _____

ADDRESS: _____

DURING THE PAST FIVE (5) YEARS HAVE YOU BEEN A RESIDENT OF:

This Nursing Home _____

Any other Nursing Home _____

Other residential facility, ie. Boarding home, group home, assisted living facility _____

Psychiatric facility _____

Mental retardation or developmental disability (MRDD) setting _____

MENTAL HEALTH HISTORY:

Have you been diagnosed by your physician as being mentally retarded or having a history of psychiatric disorders? Yes _____ No _____. If Yes, at what age were you Diagnosed? _____

1. Please indicate any major illnesses, hospitalizations, injuries or surgeries with dates/age if possible.

2. Please list current complaints/medical needs (ie. arthritis, high blood pressure, weakness, dialysis, cancer treatments or frequent constipation.

3. Current Medications:

4. Is there a history of falls? _____ Fell in the past 30 days? _____

Fell in past 31-180 days? _____

History of fractures?

Are you able to swallow pills whole? _____ Are you able to take
pills in food _____ crushed _____

DAILY ROUTINE: Please indicate the area which best describes your daily routine:

_____ stay up late at night (approximate time) _____
_____ nap regularly during day (at least one hour) _____
_____ leave home for outings one or more times per week _____
_____ stays busy with hobbies, reading or fixed daily routine _____
_____ spends most time alone and/or watching TV _____
_____ able to move about independently or with walker, cane, wheelchair _____
_____ use of tobacco products at least daily _____
_____ stable sleep pattern? Please indicate usual bed time and time you get up.
Bed time _____ Get up _____

TOILETING:

_____ independent _____
_____ need occasional assistance for safety reasons, need assistance of one or more
persons. _____
_____ incontinent of bowel: _____
_____ never _____ occasionally _____ frequently _____ colostomy _____
_____ incontinent of bladder _____ never _____ occasionally _____ frequently _____
_____ catheter _____ under garment shields _____

Does applicant waken to toilet all or most nights? Yes _____ No _____

Does applicant have an irregular bowel movement pattern? Yes _____ No _____

GROOMING AND HYGIENE:

_____ independent _____ needs supervision/assist _____ sometimes _____ partial
_____ always _____ complete

Is applicant in bed clothes much of the day? _____ Yes _____ No

BATHING: _____ independent _____ needs supervision/assist _____ sometimes _____ partial
_____ always _____ complete

Prefer: _____ Tub _____ Shower _____ Sink bath

Prefer Bathing in: _____ A.M. _____ P.M.

DIETARY HABITS:

Does applicant consume small portions, moderate or large _____

What percentage of meals provided are eaten? _____

Are there distinct food preferences? _____

Does applicant eat between meals all or most days? ____ Yes ____ No

Is there a history of weight loss: ____ Yes ____ No Please describe:

Use of alcoholic beverages at least daily: ____ Yes ____ No

FEEDING:

____ independent

____ requires some assist (ie. cutting meat, opening cartons, etc.).

____ requires supervision and encouragement to eat

____ needs to be fed

____ needs to be fed by mechanical means (ie. tube feeding)

SENSORY:

____ good vision (with or without corrective lenses)

____ difficulty reading or with other fine visual skills

____ poor vision

____ legally blind

____ nearly blind

____ blind

____ cataracts, glasses

____ hearing adequate - hearing aid ____ Yes ____ No

____ somewhat hard of hearing

____ profoundly hard of hearing

____ deaf

COMMUNICATION:

____ speech clear and distinct

____ speech somewhat impaired

____ speech profoundly impaired

____ speak foreign language (please specify) _____

BEHAVIOR:

____ generally content and cooperative

____ confused and/or disoriented

____ anxious or restless

____ depressed or cries frequently

____ paranoid

☐ wanders
☐ some memory loss
☐ significant memory loss
☐ socially inappropriate behavior (please describe _____)

☐ history of assaultive behavior
☐ history of alcohol or drug abuse

SOCIAL PATTERNS:

☐ daily contact with relatives or close friends
☐ daily animal companion/presence
☐ involved in group activities
☐ usually attends church, temple, synagogue
☐ finds strength in faith
☐ none of the above

HOW WOULD YOU DESCRIBE YOURSELF:

☐ at ease with others
☐ at ease with planned or structured activities
☐ at ease with self initiated activities
☐ establishes own goals
☐ active with community friends or neighbors
☐ able to adjust easily to change in routine
☐ none of the above

LIST HOBBIES OR INTERESTS:

Signature of Applicant

Date



Skilled Nursing Care

Date: _____

Doctor: _____

RE: _____

Dear Doctor:

An application for admission to St. Joseph's Nursing Home has been received for the above named.

A pre-admission physical form is required and it would be very much appreciated if you would complete this attached form and return it to our Social Service Office.

Thank you in advance for your assistance with this aspect of the admission process.

Sincerely,

Admissions Office

St. Joseph's Home
Ogdensburg, NY 13669

RESIDENT PRE-ADMISSION PHYSICAL FORM

Name: _____

DOB: ____/____/____

Diagnoses: _____

Prognosis: _____

General Physical Condition: _____

Functional & Cognitive Status: _____

Sensory/Physical Impairments: _____

Instructions for General Nursing Care: _____

Nutritional Status & Dietary Needs: _____

Dental Status: _____

Special Precautions: _____

Medications/Treatments: _____

St. Joseph's Home
Ogdensburg, NY 13669

Immunizations: (Dates)

Flu Shot: ____/____/____

Pneumonia Vaccine: ____/____/____

PPD: ____/____/____

Allergies: _____

Activities Potential: _____

Psychosocial Status: _____

Advanced Directives:

HCP: _____

DNR Order: _____ If yes, date of order ____/____/____

Comments: _____

I examined this Resident on ____/____/____.

Signature: _____ Date: ____/____/____