St. Joseph's Home since 1886...

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.

950 Linden Street . Ogdensburg, New York 13669
315-393-3780 . Fax: 315-393-3847
Web Site: www.stjh.org

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 since 1886...

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St. Joseph's Home
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: _____
   Address: _____
   _____
   Relationship: _____
   Telephone #: _____

2. Name: _____
   Address: _____
   _____
   Relationship: _____
   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: _____

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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

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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 applciant 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 heard 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*

St. Joseph's Home since 1886...

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

950 Linden Street . Ogdensburg, New York 13669
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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: _____/_____/_____