____
Applicant's Name

MOUNTAIN VIEW COMMUNITY

Application & Social History Intake Form

BACKGROUND

Name: ____________________________________ Date of Birth: ______/______/______ Age: __________
Prefers to be called: ________________________
Sex: Male / Female Place of Birth: ______________________________________
Mother's Maiden Name: _______________________________ Father's Name:________________________

Race/ethnicity: ____ American Indian or Alaska Native ____ Asian ____Black or African American
____ Hispanic or Latino ____ Native Hawaiian or Other Pacific Islander ____ White

Current Location: ____
____

Current Residence (excluding hospitalizations):____
____

Current Residence: __Alone __With Spouse __With family/friend __Group setting
Assistance Provided in Current Residence:
__None __Visiting nurses __Homemaker/LNA __Home health aid
__Adult daycare __Home delivered meals __Hospice __Other

If not residing in Carroll County, has the applicant ever lived in Carroll County? __Yes __No
If yes, when and in what town?____
If no, does DPOA/family member currently reside in Carroll County? __Yes __No
DPOA/family member-relation to applicant: ____

Residential/Address History (last five years)____
____

Other hospitalizations, placements, and/or institutionalizations:_____________________________
____

Is the applicant a registered voter? __Yes __No If yes, what town? _________________________

ADMISSION INFORMATION

Admission Date: ______/______/______
Admitting Diagnosis (es):____
Primary Physician Name and Address:____
____

Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition? __Yes __ No __Not a Medicaid certified unit

Condition related to MR/DD Status:
MR/DD with Organic Condition - __Down syndrome __Autism __Epilepsy
__Other organic condition related to MR/DD
__MR/DD without Organic Condition __No MR/DD

Has applicant had a Medicare-covered stay in the past 60 days? __Yes __No
If yes, when:
Start Date: _______________________ End Date: ____________________________

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Legal Status: ___Self ___Legal Guardian ___Guardianship Proceedings
Advanced Directives: ___Health Care POA ___Living Will ___DNR order ___Other

Progression towards placement____
____
____
Did the applicant participate in the decision? Yes / No Please explain:_______________________
____

FAMILY INFORMATION
Marital Status: ___ Married ___ Divorced ___ Separated ___ Widowed ___ Single

Husband/Wife (Maiden) Name: ________________ If deceased, date of death: __________
Number of Marriages: _____ Number of Siblings: _____
Number of Children: _____ Grandchildren: _____ Great-grandchildren: _____

History:____
____
____
____
____

Family Roles/Involvement: ____
____
____
____

EDUCATION/MILITARY & OCCUPATIONAL HEALTH
Schools attended: ____
____
Highest Grade completed: ______________ Military Service/Branch:______________________

Previous occupation(s)/Specialized training: _______________________________________
____
Retirement/most recent employment: ____

RELIGIOUS BACKGROUND/INTERESTS
Religious Preference: __________________ Church: ______________________________
Name and Phone # of involved Clergy: ____
COMMENTS/interests in attending services:_______________________________________

COMMUNICATION and COGNITION
Primary Language: __________________ Other Languages: __________________________
Speech: ___Clear ___Difficult to understand ___Non-verbal
Does the applicant need or want an interpreter to communicate with a doctor or health care staff?
___Yes ___No

Able to read/write: Yes / No Understands/responds: Yes / No
Verbal Ability: Good / Fair / Poor Can communicate needs: Yes / No
Communication Problems/Deficits (review MDS): ______________________________________
____
____

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Orientation: ___Person ___Place ___Time ___None

Decision Making: ___Independent ___from 2 choices ___with cues/supervision ___unable

Ability to follow directions: ___multi-step ___1-step ___with cues/demonstration ___unable

Memory: ___Able to recall recent events ___Poor short term memory
___Able to recall past events ___Poor long term memory
___Some recall with cues/reminders ___Intact

Vision: ___Wears glasses ___Needs large print ___Assistive Devices:______________________________
Hearing:____

RECREATION ASSESSMENT/INTEREST (Hobbies or Talents)
Applicant's present interests: ____
____
____
Applicant's past interests: ____
____
____
Musical Preferences:____
Independent Pursuits: ____
Community Involvement: ____

PHYSICAL FUNCTIONING
Mobility: ____
Lower Extremities: ________________________ Upper Extremities: ______________________________
Dietary Order: _____________________________ ___ ___Needs assistance with dining

Mood/Behavior: ____
____
Barriers/Adaptions: ____
____
Preferences for Customary Routine and Activities
How important is it for you to:
CODING: 1-very important 2-somewhat important 3-not very important
4-not important at all 5-important, but can't do or no choice
9-no response or non-responsive
Daily Preferences:
___choose what clothes to wear?
___take care of your personal belongings or things?
___choose between a tub bath, shower, bed bath, or sponge bath?
___have snacks available between meals?
___choose your own bedtime?
___have your family or a close friend involved in discussions about your care?
___be able to use the phone in private?
___have a place to lock your things to keep them safe?
Activity Preferences:
___have books, newspapers, and magazines to read?
___listen to music you like?
___be around animals such as pets?
___keep up with the news?
___do things with groups of people?

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___do your favorite activities?
___go outside to get fresh air when the weather is good?
___participate in religious services or preferences?

Primary respondent: ___resident ___family/significant other ___information could not be completed

Staff Assessment: Completed ONLY IF Resident/Family is unable to complete the above interview

___choosing clothes to wear
___receiving a tub bath
___receiving bed bath
___snacks between meals
___use of private phone
___listening to music
___keeping up with the news
___participating in favorite activities
___spending time outdoors
___reading books, newspapers, magazines
___caring for personal belongings
___receiving shower
___receiving sponge bath
___staying up past 8:00pm
___place to lock personal belongings
___being around animals such as pets
___doing things with groups of people
___spending time away from facility
___participating in religious activities
___family/significant other involvement in care discussions

Feels comfortable in: ___individual setting ___small groups ___Large groups ___community

Initiates Social Contact: ___independently ___with prompts/cues ___resists social contact ___unable

Participation/engagement: ___independent ___verbal ___physical ___needs cues/demonstration ___passive

Is the applicant affiliated with any organizations? ___Yes ___No
If yes, which affiliations? ____

RecreationPlan:____
____
____
____
____
____
____
____
____
____

ALCOHOL/DRUG HISTORY & HABITS

Is there a history of drug and/or alcohol use? ___Yes ___No
If yes, please explain: ____
____
Would the applicant have a physician's order to have alcohol? ___Yes ___No
Is the applicant a smoker? ___Yes ___No Is applicant a safe smoker? ___Yes ___No
Additional information: ____
____
Additional habits: ____
____

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MOUNTAIN VIEW NURSING HOME

Please attach copies of supporting documents for:
Guardianship, POA, proof of insurance, life/health insurance policies, living will, & prepaid funeral contracts

Primary contact person: ______________________ Relationship to applicant: ______________
Address: ____
City/State/Zip: ____
Home Phone: ____________ Work Phone: ______________________ Ext. ________
Email Address: ____
Check all that apply: ___Guardian of the Person ___Guardian of the Estate ___POA/Commercial
___ POA/Medical ___Other

Alternate contact: ______________________ Relationship to applicant: ______________
Address: ____
City/State/Zip: ____
Home Phone: ____________ Work Phone: ______________________ Ext. ________
Email Address: ____
Check all that apply: ___ Guardian of the Person ___Guardian of the Estate ___POA/Commercial
___ POA/Medical ___ Other

Alternate contact: ______________________ Relationship to applicant: ______________
Address: ____
City/State/Zip: ____
Home Phone: ____________ Work Phone: ______________________ Ext. ________
Email Address: ____
Check all that apply: ___ Guardian of the Person ___Guardian of the Estate ___POA/Commercial
___ POA/Medical ___ Other

SOURCES OF INCOME:
Social Security #:______________________ SSI: ______________________
Veterans#:______________________ Railroad Retirement #: ______________
Other Income: ______________________ Id#: ______________________

INSURANCE (MEDICAL):
Medicare #: ______________________ Medicaid #: ______________________
BC/BS #: ______________________ Group #:__________ Plan #: ________
AARP #: ______________________ Group #: __________ Plan #: ________
Long-Term Care Insurance #:______________ Name: ______________________
Other Insurance #:______________________ Name: ______________________

Has the applicant applied to Medicaid Services? If so, when was the application submitted? __________

OTHER INFORMATION:
Living Will/Terminal Care Document? Yes / No Prepaid Burial Plan? Yes / No
Donor Card or Donor Document? Yes / No

Funeral Home/Mortician Name: ______________________________________
Address: ____
Phone:____
Cemetery Name: ____
Address: ____
Phone: ____
Signature of Applicant or Representative: ______________________ Date:__________