Elder Options, Inc.
Care Management and Home Care

ASSISTED LIVING WAIVER INTAKE FORM

CLIENT INFORMATION (person needing program)

Residing:
☐ Alone ☐With Family ☐Assisted Living ☐SNF ☐Other

Name:_____ DOB: _____ Does client have POA?: Yes No

Address: _____ Phone Number: _____
(Include facility name if applicable)

Medi-Cal Number: _____ Issue Date: _____

Share of Cost? Yes No Monthly Income: _____ SS/SSI/Disability

Diagnosis (use actual and detailed diagnosis information –whatever info you can think of):

Approximate Weight: _____ Approximate Height: _____

Open Wounds: Yes No If Yes, where and why? _____

Diabetes: Yes No If Yes, do they require injections? Yes No

If Yes, are they administering their own injections and taking their own blood sugar levels? Yes No

Using a Hoyer Lift: Yes No

Is the client considered physically non-ambulatory (requiring more than a cane to move or walk around)? Yes No

Can the client mentally and physically leave a building without assistance? Yes No

If client needs assistance what type?

Is the client a fall's risk? Yes No Does the client have a history of falls? Yes No

Primary Care Physician: _____ Phone Number: _____

Activities of Daily Living (ADL's) –SCORE USING RUBRIC:
Scoring (Must be scored 0-4):
0 Independent-No assistance or oversight
1 Supervision-Oversight, encouragement, cueing, or set up assistance needed
2 Limited Assistance- Motivated by activity, but receives physical assistance
3 Extensive Assistance-Performs part of activity, weight bearing support is provided
4 Total Hands On-Needs complete hands on assistance to complete activity.
* Must require assistance with numerous ADL activities in order to qualify.

_____ **Bed Mobility:** Can the individual move and position themselves in bed?
_____ **Transferring:** Can the client safely transfer between surfaces, i.e. bed to chair, etc?
_____ **Ambulation:** Can the client move about their room or other areas of the residence safely, i.e. walk independently to dinner, for a walk, etc.
_____ **Dressing:** How much assistance is required for dressing or undressing?
_____ **Eating:** Can the client eat if a meal is prepared? Is additional assistance needed, i.e. cutting of food, feeding, etc.
_____ **Toilet Use:** Can client toilet independently? Assistance needed with transfers on and off? Assistance with depends changes?
_____ **Personal Hygiene:** Can client maintain personal hygiene independently? Are cues required?
_____ **Bathing:** Assistance needed for full bath and shower, i.e. set up, stand by, etc?

Assistive Devices:
☐ Walker ☐ Wheel Chair ☐ Bed Rails ☐Shower Chair ☐ Cane
☐ Feeding Device ☐ Dressing Device ☐ Other

Continence:
☐ Bowel ☐ Bladder Assistance Needed, how? _____

Medication Information:
_____ Total Number of Medications (Include PRN, OTC, and Prescribed)

Injections Required: Yes No Able to Administer Injections: Yes No

Medication Allergies: Yes No List: _____

Food Allergies: Yes No List: _____

Requires Assistance: Yes No How: _____

Mental Health/Cognitive Impairment:

☐ Dementia ☐ Alzheimer's ☐ Depression ☐ Bi Polar ☐ Anxiety
☐ Schizophrenia ☐ Developmental Delay ☐ Other: _____

POA OR CLIENT REPRESENATIVE INFORMATION

Name: _____ Relationship: _____ POA: Yes No

Address: _____
(Only if client is living with caller or caller is POA for healthcare)

Home Phone: _____Cell Phone: _____ Email: _____

How did you hear about the ALW Program: _____

Have you looked at ALW facilities? _____

Is the individual aware and willing to enter the ALW program? _____ YES _____ NO

Chosen Facilities (from list, need top two choices): _____

ADDITIONAL NOTES: