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Application for Bello Machre Residential Services

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Individual Information

Date:		Individual Requiring Residential Services:					
Social Security Number:				Date of Birth:			
Height:		Weight:		Hair Color:		Eye Color:	
Gender:		Blood Type:		Identifying Marks:			
Physical Description:							
Birth Country:		Birth State:		Birth County:		Birth City:	
State Residence:		Legal Status:		○ Competent / ○ Incompetent			

The above information will help Bello Machre to develop a comprehensive Individual Plan and Face Sheet and in no way determines admission or placement into Bello Machre.

Parent/Guardian Name (1):			
Address:			
Home Phone #:		Cell Phone #:	
Email Address:			

If any information is the same (above), please leave blank.

Parent/Guardian Name (2):			
Address:			
Home Phone #:		Cell Phone #:	
Email Address:			

If the individual has a Guardian of Person, Guardian of Property, or a Medical Decision Maker in place at this time, please provide copies of the appropriate legal paperwork for our records along with contact information.

All fields are required. Incomplete applications will be returned for further information

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Pertinent Medical Information

Current Medical Diagnosis	
Psychological Diagnosis (ex: Level of Intellectual Disability, ADHD etc…)	
Allergies (to include medication, food etc…)	
Assistive Devices (ex: wheelchair, cane, walker, hospital bed, tube feeding, suction, braces, glasses, hearing aid, wedges, etc…)	

Insurance:

Primary Insurance:	Name on Card: Policy/ID Number:	Phone Number:
Secondary Insurance:	Name on Card: Policy/ID Number:	Phone Number:
Tertiary Insurance:	Name on Card: Policy/ID Number:	Phone Number:
Primary Insurance:	Name on Card: Policy/ID Number:	Phone Number:

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Pertinent Medical Information

Yes	No	Condition	Yes	No	Condition
		Any conditions that affect breathing?			Any conditions that affect digestion?
		Conditions that affect the heart?			Any conditions that affect going to the bathroom?
		Conditions that affect mobility?			Any conditions that affect safety?
		Conditions that affect the skin?			Dialysis
		Cardiac Condition (at risk or history of)			Hearing Impairment
		Stroke (at risk or history of)			Vision Impairment
		Hypertension			Speech Impairment
		Chronic Obstructive Pulmonary Disease			Mobility Impairment
		Frequent Pneumonia			Dentures
		Asthma			Anxiety/Agitation
		Seizure Disorder			Neurological Conditions
		Difficulty Swallowing/Chewing			Sleep Disorders
		Difficulty Drinking			Psychiatric Disorders
		Constipation			Reproductive Disorders
		Diarrhea			Thyroid Disorders
		Incontinence			Diabetes
		Skin Breakdown/Rashes			Combative/Aggressive Behaviors
		Circulation Disorder			Self Injurious Behaviors
		Arthritis			Communicable Disease
		Osteoporosis			Tuberculosis

If you have checked "Yes" for any of the above, please explain in detail. Please include whether the individual is currently receiving care for any of the above.

Please also use this space to include any additional information/medical history for the individual.

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Pertinent Medical Information

Immunizations:

Immunization	Date
Influenza	
Pneumonia	
Chicken Pox (if the individual did NOT have chicken Pox previously)	
Shingles	
T-Dap	
Tetanus	
Hep B	
*TB/PPD	

*Tuberculosis screening (with results) is needed within 90 days of beginning services.

Hospitalizations:

Please list all recent Hospital Dates within a 5 year period (please include all surgeries – including outpatient)	
Reason for Hospitalization:	Date:

Pertinent Medical Information

Medications:

Please list all Medications the individual currently receives Please include any PRN (as needed) medications such as Tylenol, Tums, Multivitamins				
Medication:	Dose:	Time:	Reason:	Prescribing Doctor:

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Physicians and Healthcare Professionals

Name	Address	Phone/Fax Number
Primary Care Physician: _____		P: F:
Dentist: _____		P: F:
Eye Doctor: _____		P: F:
Audiologist: _____		P: F:
Neurologist: _____		P: F:
Nutritionist: _____		P: F:
Podiatrist: _____		P: F:
Speech/Language: _____		P: F:
Occupational/Physical Therapist: _____		P: F:
Psychologist/Psychiatrist: _____		P: F:

Physicians and Healthcare Professionals

Other:_____ _____		P: F:
Other:_____ _____		P: F:
Other:_____ _____		P: F:

Please list the most recent appointment dates for the physicians/healthcare professionals listed above:

Physician/Healthcare Professional	Date of Last Appointment	Scheduled Upcoming Appointments
Primary Care Physician		
Dentist		
Eye Doctor		
Audiologist		
Neurologist		
Nutritionist		
Podiatrist		
Speech/Language		
Occupational/Physical Therapist		
Psychologist/Psychiatrist		
Other:		
Other:		
Other:		

A copy of the most recent appointment records should be obtained from all of the physician/healthcare professionals listed above and given to the Bello Machre representative

Diet/Nutritional Information

Special Diet (ex: Low Cholesterol, Low Fat etc…) *Please list any supplements that the individual takes (Ensure, Boost etc…)*	
Diet Consistency (ex: Regular, Chopped, Pureed…)	
What is the individual's level of independence when eating? *Please list preparations staff should make (ex: staff will have to cook the meal **or** staff will be responsible for cooking and cutting the foods **or** staff will be responsible for all meal prep and will assist in feeding)*	
Will the individual require supervision when eating? *Please list needs when eating (ex: staff will need to prompt to slow down when eating **or** staff should ensure that sips of water and spoonfuls of food are alternated)*	
What kinds of food are preferred? *Please list any foods that are enjoyed by the individual.*	
What kinds of food are disliked and should be avoided?	
Is any adaptive equipment used to assist in feeding? *Please note any special/preferred dietary needs (ex: Sippy Cup with handles, Large Handled Spoon, Scoop Plates etc…)*	

Diet/Nutritional Information

G-Tube Information (*only if applicable*):

If a G-Tube is used for the individual, please list the uses. *(ex: for all nutritional needs **or** for supplemental needs and medications)*	
If the individual is NPO (no food by mouth), are pleasure feedings used? Have pleasure feedings been ruled out?	
Please list the form of feeding that is used. *(ex: Bolus, Pump etc…)*	
Please list all specifications for the Feeding Supplies used. *(ex: type of tube – Mickey etc…, size of tube, brand of pump etc…)*	
Please list the company that is currently servicing any of the Feeding Supplies. *(ex: what company is currently supplying the formula, what company is servicing the pump etc…)*	
What is the current formula being given? And what is the current Tube Feeding Regimen? *(ex: Brand of Formula, given via continuous pump 7am – 6pm at a rate of ___per hour **or** 1 can given via bolus at 7am, 12pm, 3pm and 6pm)*	
Historical Information: When was the G-Tube placed? Why was the G-Tube placed?	
G-Tube Related Behaviors? Does the individual pull at the G-Tube/G-Tube site?	
G-Tube Related Issues? Does the individual have any ongoing issues with the G-Tube or G-Tube site? *(ex: any redness, soreness, bleeding, leaking, poor fit etc…)*	

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Financial Information

Name of the Primary Caregiver:		DOB of the Caregiver:	
Relationship to the Individual:		Phone Number of the Caregiver:	
Address of the Caregiver:			

Please list all known income and benefits the individual is receiving on a monthly basis:

SS:		Veterans Benefits:	
SSI:		Food Stamps:	
SSDI:		AFDS:	
Others: Please list any Trust Funds, Burial Plots etc…			

Name and Claim Number (usually Social Security Number) if benefits are paid on behalf of a parent and/or other family member:

Name:		Claim Number: (Social Security Number)	

Information for the current Representative Payee (if different from the Primary Caregiver):

Name of Rep Payee:		Phone Number of Rep Payee:	
Address of Rep Payee:			

A Representative Payee Form/Letter is included in your application packet. Please have the individual and/or the legal guardian of the person sign this letter.

Please provide copies of recent bank account statements.

Our finance department will apply for Representative Payee once they have received all necessary documents. The Rep Payee application process may be lengthy due to circumstances beyond our control and it may take time before benefit checks are changed over to Bello Machre. Once the individual has moved into Bello Machre, it is the Primary Caregiver's/current Rep Payee's/ Guardian's responsibility to remit all benefit checks to Bello Machre's Financial Office upon receipt.

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Additional Information

Our goal is to learn as much as possible about the individual applying for residential services with Bello Machre. The information provided to us will help us give the highest level of care.

Medical Directives:	
Who will act as the medical decision maker in case of emergency for this individual? (*We need a contact other than the individual, even if they are their own guardian)*	
Does the individual have any medical advanced directives in place? (Please provide a copy)	
Domestic Skills: Food Preparation	
Can the individual use the oven? Please list the level of assistance needed	
Can the individual use the stove? Please list the level of assistance needed	
Can the individual use the microwave? Please list the level of assistance needed	
Can the individual use the toaster oven? Please list the level of assistance needed	
Can the individual prepare meals? Please be specific (a sandwich, a cup of soup)	
Does the individual take a lunch with them to work/the day program? Do they assist in the preparation of the lunch? Please list what the typically like to take	
Domestic Skills: Dressing	
How much assistance does the individual need to dress?	
Does the individual need help with buttons, belts, shoestrings, zippers etc? Please be specific	
Does the individual need help with picking out appropriate clothing? (Sweaters for cold days, T-Shirts for hot days)	
Does the individual have a particular style or a particular outfit they like to wear?	
Will the individual need help from staff to purchase new clothes?	

Domestic Skills: Financial	
Is the individual able to count?	
Is the individual able to recognize monetary values? (please be specific – can they identify nickels, dollar bills, differentiate between a one-dollar bill and a five-dollar bill)	
Does the individual manage their own money? Please elaborate on how much assistance the individual needs with managing money.	
If the individual has a bank account, do they need assistance with deposits, withdraws and balancing their funds?	
Does the individual have any financial goals that we should be made aware of? Are they saving up for anything in particular?	
Domestic Skills: Home Life	
Is the individual able to do their own laundry? What level of assistance do they need? Do they have a preference of which day of the week their laundry is done?	
Is the individual able to clean their own room? What level of assistance do they need? Is the individual able to clean other areas of the home (bathroom, kitchen, living room)? Do they enjoy cleaning? Is there something about cleaning that they like or do not like?	
Does the individual enjoy working outside/doing yard work? What level of assistance do they need?	
Domestic Skills: Time and Punctuality	
Is the individual able to tell time?	
Does the individual wake independently?	
Does the individual schedule appointments and/or activities on their own?	
Self Care: Toileting	
Is the individual continent? Does the individual wear diapers/pull ups (all through the day or only at night)?	
If the individual is continent, what level of assistance do they need with toileting? Please be specific such as: reminders, transfers, cleaning etc.	

Does the individual require any adaptive equipment for toileting? Please be specific such as: handle bars, riser, separate commode chair in room, etc.	
Self Care: Bathing and Personal Hygiene	
Does the individual prefer taking a bath or a shower? What level of assistance is needed? Please be specific such as: total staff assistance, transfers, reminders, etc.	
Can the individual be left alone in the bathroom for any amount of time? Please be specific about when this should occur such as: staff should never leave the individual alone in the bathroom, staff should leave the individual alone in the bathroom at all times, only for toileting, only for showering/bathing, etc.	
Does the individual require any adaptive equipment for bathing needs? Such as shower chair/bench? If yes, please be specific about what type of equipment is needed such as: swivel seat, back support, side bars/rails, on wheels/rolling, head rest, foot rest, etc.	
Does the individual need additional assistance with hair washing and/or drying? Please include if the individual is independent but may need reminders.	
Does the individual need assistance with shaving? Please include if the individual is independent but may need reminders.	
Does the individual need assistance with brushing their teeth? Please include if the individual is independent but may need reminders.	
Does the individual need assistance with nail clipping? Please include if the individual is independent but may need reminders.	
Self Care: Sleeping Habits and Needs	
About how many hours of sleep does the individual need/or like to get?	
Does the individual often get up to use the bathroom during the night? (If so, we will refer to the *Self Care: Toileting* section to determine the level of staff assistance that is needed)	

Does the individual get up throughout the night? If so, does the individual wander or become active? Please be specific such as: walking around, opening doors/cabinets, eating, watching TV, listening to music,	
Does the individual require any medical treatments or medications through the night?	
Does the individual experience increased confusion and/or agitation at night?	
Does the individual require their undergarments to be checked/changed throughout the night? **Please note, that any individual who is considered "total care", relies on staff for toileting needs and is unable to reposition themselves at night will be placed on a Turning and Repositioning schedule throughout the night about every 2 hours at which time their undergarments will be checked/changed as needed.*	
Self Care: Safety	
Does the individual have any alone time? Please elaborate and include details such as: • The amount of time they should/can be left alone • The environment they should/can be left alone (ie: only in the home, and not in the community) • The parameters around their alone time (ie: staff should call and check in on them every 2 hours)	
Does the individual know how and when to call 911?	
Does the individual know not to allow strangers/unknown persons into the home?	
Does the individual know not to accept a car ride or go off alone with a stranger/unknown persons?	
If told how to evacuate the home in the case of an emergency (ie house fire) how much assistance will the individual need to vacate the premises?	
Is the individual able to safely cross the street without assistance?	
Does the individual need prompting and/or assistance to use the seat belt while riding in a vehicle?	
Can the individual self-regulate water temperature?	

Medical	
Does the individual know when they are not feeling well? If the individual is not verbal, are their other indications that staff should look out for that would alert them that the individual is not feeling well?	
Is the individual truthful about being sick and /or in pain? Does the individual exhibit any attention seeking behaviors centering around the claim of not feeling well or being hurt?	
Does the individual schedule doctor's appointments? Will the family remain involved in scheduling doctor's/medical appointments? **Please note, it is the common practice of Bello Machre for the Family Living Director to schedule doctor's appointments, but if other arrangements are in place, we would be happy to assist the individual and/or family with scheduling appointments and arranging transportation.*	
Is the individual able to self-medicate? Please elaborate on the level of assistance needed such as: staff will need to remind them when to take their medication, staff will need to hand them the correct medication, etc.	
Language Expression:	
Is the individual able to read? Please identify the level of reading they are comfortable with. Is the individual able to identify their name?	
Is the individual able to write? Please identify the level of writing skill they are comfortable with. Is the individual able to write their own name?	
Does the individual use/or is able to use complete sentences when communicating?	
Is the individual easy to understand when communicating? What are some difficulties?	
Does the individual use a communication device? If so, what kind of device is it? Is the individual able to use the device independently? What is the level of assistance needed? (ie prompting/reminding to use or how to use)	

Does the individual enjoy/or is able to speak on the phone? What level of assistance is needed? (ie staff will need to dial the numbers, staff will need to hold the phone etc.)	
When communicating, is the individual always truthful? Does the individual have a history of making false allegations?	
How does the individual act when they become upset? Are they able to communicate what is upsetting them? What is the best way for staff to assist the individual when they are upset? (ie: redirect them, encourage them to talk)	
Gross and Fine Motor Skills:	
Is the individual ambulatory?	
If the individual is ambulatory, what, if any, difficulties do they have? Are they able to walk on uneven terrain? Are they able to walk up and down stairs? What level of assistance is needed?	
Is the individual able to open/turn doorknobs? Is the individual able to use/turn a key?	
Community Life: Social Interaction	
Who does the individual like to spend time with? Please list some names of people close to the individual such as family members, friends, co workers, neighbors, church family, volunteer partners, etc. It is very important that our individuals continue to have healthy social interaction with anyone they are close to and Bello Machre works hard to help maintain and foster those relationships.	
Does the individual participate or belong to any groups, clubs, circles or group meetings such as Boy/Girl Scouts? If this group meets regularly, please provide us with the details such meetings dates/days, times, locations, point of contact, etc. Please let us know if staff will need to accompany and stay with the individual during these meetings.	

Home Life:	
What does the individual like to do when they are home? Does the individual enjoy watching TV or movies? Please share some favorite TV shows and/or movies. Does the individual enjoy listening to music? Please share some favorite types of music and/or favorite songs/artists.	
Is the individual social when at home or do they prefer to be left to themselves?	
Do they enjoy any activities such as cards, puzzles, board games?	
Vocational: Work Life/Day Program	
Does the individual attend a Day Program or are they employed? Please share with us where they attend/or are employed. Please also share if this will change if they are admitted to a Bello Machre home (ie Day Program will need to change because of location)	
Does the individual enjoy their day program/place of employment? Please share with us what they do at their job or at their day program.	
Does the individual earn a paycheck?	
Does the individual participate in any activities such as art class, dance, drama etc? Please share with us the details of this if they do such as where and when the activities are held. If not, would these types of activities be something that the individual would enjoy?	
Likes and Dislikes:	
Please use this space to tell us any other likes and dislikes that we should be aware of in order to provide the individual with the highest level of care and a happy, healthy home environment.	

Future Planning: Goals	
Where would the individual like to live in the future? Is a Bello Machre home a long-term goal or would they like to work towards independent living or another living arrangement (with a roommate, with a family member, etc.)	
Are there any long-term goals that we can help the individual to achieve? This can include traveling, becoming more financially independent, learning to cook etc.	
Are there any short-term goals that we can help the individual to achieve? This can include vacationing once a year, attending a Raven's game, going to a concert, participating in Special Olympics etc.	
Future Planning: Retirement and Beyond	
Individuals at Bello Machre either attend a Day Program or are employed during the day. As our individuals age, we like to work towards making their days comfortable for them and making retirement possible within the home by providing staff during the day. The idea of retirement may be a far off idea or it may be something to consider in the near future for the individual. We would like to get an idea of how retirement and beyond should be handled so that we can help to work towards that goal.	
How would the individual like to spend their retirement? (ie in the home or at a Senior oriented day program)	
Have any end of life arrangements been made at this time? Please share with us choices such as burial or cremation. If not, would you prefer that Bello Machre assists in making arrangements and/or setting aside funds each month for these arrangements?	
Does the individual have a Life Insurance Policy?	
Does the individual have a Burial Plot?	
Emergency Planning:	
In the event of an emergency, what would be the ideal steps that should be taken for the individual? Should the individual shelter in place with staff (or evacuate with staff), or should the individual be taken to a relative or guardian?	

In the event of an emergency, Bello Machre should contact the following:			
Name:			
Address :			
Relationship:		Phone Number:	

Statement of accuracy, release of information and permission to obtain medical care:

I _____ hereby note that the information listed on
(Individual completing this form/Guardian of the individual)

this application in regards to _____ is accurate to the
(Name of Individual/Applicant)

best of my knowledge. In the unlikely event of a medical emergency, I understand that every effort will

be made to contact me. In the event I cannot be reached, I hereby give permission for an agent of

Bello Machre to secure and authorize proper treatment for the above individual. I also give permission

for _____
(Agency/Provider, Doctors/Specialists)

to release any and all requested information and/or records of the above individual to an agent of

Bello Machre, Inc.

Individual/Applicant's Signature: _____ Date: _____

Signature of person completing this form
and/or the Guardian of the Individual/Applicant: _____ Date: _____

Representative of Bello Machre, Inc.: _____ Date: _____

Bello Machre does not discriminate on the basis of gender, sexual preference, race, color, religion, national origin, marital status, age, disability, or any other characteristic protected by law.