



MALACHI HOUSE

A loving home for life's last journey

Standards for Admission

Will accept residents with:

DIAGNOSIS:

Lithium with lab monitoring
Psych diagnoses managed by medication
MRSA wound

CARE:

Peg tubes with bolus feeding only
Colostomy
Urostomy
Chest tubes that hospice staff manages
Foley catheter
Injections done by hospice staff
Wounds with simple dressing changes
Trach without suction
O2 Therapy/CPAP/BIPAP

Will not accept residents with:

DIAGNOSIS:

Insulin dependent diabetics
Blood sugar monitoring
Confused residents that wander
MRSA lung
Active TB

CARE:

Suction
Ventilator support
Active alcohol or drug addiction
Electric wheelchair or scooter-

Applicant must have:

Limited financial resources. Each will be considered on an individual basis.
No willing, available, or competent caregiver.
Care provided by a hospice team.
DNR-CC order per State of Ohio form
Results of a chest X-Ray or TB test performed within the past 6 months.
Funeral arrangements made in advance.



A loving home for life's last journey

2810 Clinton Avenue
 Cleveland, OH 44113
 216.621.8831 phone
 216.621.8841 fax

Office Use Only	
Resident #:	_____
Admit Date:	_____
Expired:	_____
Discharged:	_____

APPLICATION FOR RESIDENCY

Malachi House, created out of a Christian sense of ministry, serves persons who are terminally ill, without cost or regard to gender, race, religion or national origin. This home ministers to individuals who need an available caregiver, who have limited or no financial resources and are in need of special home care in the final stages of life. A trained staff and volunteers provide spiritual, emotional, and physical support with the assistance of a hospice team.

Name: _____ Phone: _____

Address: _____

SSN: _____ Date of Birth: _____

Age: _____ Sex: _____ Ethnicity: _____

DIAGNOSIS:

What is your primary diagnosis?: _____

Do you have:

Tuberculosis	Yes	No	Insulin dependent diabetes	Yes	No
Feeding Tube	Yes	No	I.V.	Yes	No
Do you require:			Sub Q Medication	Yes	No
Respirator/Trach	Yes	No	Injectable Medication	Yes	No

WE DO NOT TAKE INSULIN DEPENDENT/GLUCOSE-MONITORED RESIDENTS

HOSPICE:

Are you in a hospice program now? Yes No

If no, are you willing to enter a hospice program? Yes No

If yes, what is the name of the hospice? _____

CAREGIVER:

Do you have a caregiver now? Yes No

If yes, who is your caregiver? _____

Caregiver phone: _____ Caregiver address: _____

If your caregiver is no longer willing or able to take care of you please explain: _____

POWER OF ATTORNEY:

Do you have a health care P.O.A.? Yes _____ No _____ HC P.O.A Phone: _____

General/Financial Health Care P.O.A. Name: _____

P.O.A. Address: _____

ALL AREAS MUST BE COMPLETED

FINANCIAL FORM

(This information will be used **ONLY** to determine eligibility)

Medicare #: _____ Medicaid #: _____

Total monthly income: \$ _____ from SSI or SSD Pension other

Total monthly expenses: \$ _____

Savings account Yes No If yes, current balance: \$ _____

IRA, 401k, Investments Yes No If yes, current balance: \$ _____
Stocks, Bonds

Checking Account Yes No If yes, current balance: \$ _____

Do you own: home/property? Yes No If yes, estimated value: \$ _____

1st mortgage balance: \$ _____ 2nd mortgage balance if applicable \$ _____

ATTACHMENTS:

The following items **MUST** be attached to the application:

Completed & Signed DNR Form Current Chest X-Ray (within 6 months)

Malachi House Transfer Form History & Physical

REPORT CALLED ON DAY OF ADMISSION

IS RESIDENT A VETERAN? Yes No

FUNERAL HOME ARRANGEMENTS NEED TO BE IN PLACE BEFORE ADMISSION:

Name of Funeral Home: _____

Address: _____

Telephone: _____

I understand and agree that my residency at Malachi House may be re-evaluated at any time for changes in diagnosis, prognosis, or behavior. The information I have provided here is true and accurate to the best of my knowledge.

Applicant

Person Signing for Applicant

Date

Office Use Only	
Approved By: _____	Date: _____



REFERRAL INFORMATION FORM

A loving home for life's last journey

Patient Name: _____ SSN: _____
Home Address: _____
City: _____ State: _____ Zip: _____
County: _____ Date of Birth: _____
Marital Status: Single Married Divorced Widowed Separated
Religion: _____ Church: _____

MEDICAL INFORMATION:

Principal Diagnosis (include date of onset): _____

Other Diagnosis: _____
Prognosis: _____
Allergies: _____
Brief history/course of treatments/tests/surgeries (include dates): _____

Test: **Date:** **Result:**
Chest X-Ray _____ _____ ATTACH A COPY TO THIS APPLICATION
PPD _____ _____ ATTACH A COPY TO THIS APPLICATION

MRSA Yes No Site: _____

MEDICATION

Does patient refuse to take medications: Yes _____ No _____ Sometimes _____

Diet: _____ **Consistency:** _____

Referral Made By: _____ **Date:** _____



A loving home for life's last journey

PRESENT PATIENT LOCATION:

If not in hospital, present patient location: _____

Present address: _____

Contact: _____ Phone: _____

HEALTH CARE POWER OF ATTORNEY:

Name: _____

Address: _____

Relationship: _____ Phone: _____

FAMILY / FRIEND / GUARDIAN:

Name: _____ Relationship: _____ Address: _____ Phone: _____

COMMUNITY AGENCIES ACTIVE WITH PATIENT:

Agency Name: _____ Staff: _____ Phone: _____

SOCIAL SERVICE ASSESSMENT / RESIDENT OR FAMILY: Please comment on each

Family relationship/support: _____

Home environment (physical & social): _____

Over the past six months have the resident, family, or hospice team noticed a problem with:

Lice: _____

Bedbugs: _____

Cockroaches: _____

Other: _____

Sitter/Restraints-Free minimum of 24 Hours: _____

Cognitive/Emotional/Coping Status: _____

Additional problem areas: _____

History of Smoking: _____

History of alcohol abuse: _____

History of drug abuse: _____

Psych history: _____

History of domestic violence: _____

SW/RN signature: _____

RESIDENT PSYCHO-SOCIAL HISTORY



A loving home for life's last journey

Patient Name: _____ Admit Date: _____

Social Worker: _____ Phone: _____

Diagnosis: _____

Other disease processes (physical/psychological): _____

FUNCTION LEVEL:

Physical: _____

Psycho-social: _____

MENTAL:

- Alert
 - Lethargic
 - Comatose
 - Oriented
 - Disoriented
 - Confused
 - Dementia
 - Forgetful
- _____
- _____
- _____

AFFECT:

- Cheerful
 - Superficially Cheerful
 - Calm
 - Hostile
 - Flat, Blunted
 - Fearful
 - Anxious/Agitated
 - Depressed
 - Tearful
 - Other (explain)
- _____
- _____

ATTITUDE & BEHAVIOR:

- Disruptive
 - Helpful
 - Thoughtful
 - Withdrawn
 - Resistive
 - Immature / Regressed
 - Aggressive
 - Preoccupied
 - Manipulative
 - Seeks reassurance
 - Seeks attention
 - Anxious
 - Other (explain)
- _____
- _____
- _____
- _____

ACTIVITY:

- Ambulatory Ad Lib
 - Ambulatory w/Assist
 - Assistive Device
 - Transfer to bed
 - Bedbound
- _____

VERBILIZATION:

- Non-Verbal
 - Verbalized only when questioned
 - Verbalized spontaneously
 - Other (explain)
- _____
- _____

RELEVANT HISTORY, CURRENT DYNAMICS, CURRENT ISSUES:

FAMILY:

Spouse: _____ Parents: _____

Children: _____

Siblings: _____

Other: _____



PATIENT NAME: _____

A loving home for life's last journey

NURSING SUMMARY:

Cardio-Pulmonary:

 Temp: _____ O Ax R Secretions
 Pulse: _____ AP R Quality Describe: _____
 BP: _____ R L Tracheostomy
 Resp: _____ Depth and Quality: _____ Size: _____ Type: _____
 Oxygen Used/Breathing Treatment: _____ Rate: _____ Method: _____

NUTRITION / HYDRATION:

 Height: _____ Diet: _____ Feeds Self Dehydration
 Weight: _____ Assist Feed Edema
 Teeth Total Feed Nausea
 No Teeth Consistency: _____ Hyperalmentation Vomiting
 Dentures Type Feeding Tube Type Dysphagia
 Denture with Patient Date Inserted: _____ Poor Appetite

SENSORY / COMFORT:
VISION: Adequate Poor Blind Glasses Contacts
HEARING: Adequate Poor Deaf Aid In Ear _____
SPEECH: Good Difficult Unable
 Language: _____
COMFORT: Pain Yes No
 Where/When: _____
SENSORY AIDS:
 PT has them Yes No
 PT uses them Yes No

PSYCHOSOCIAL:
MENTAL STATUS:
 Alert
 Lethargic
 Comatose
 Oriented
 Disoriented
 Confused

BEHAVIOR:
 Wanders
 Cooperative
 Combative
 Forgetful
 Sleep Problems
 Other - specify: _____

AFFECT:
 Flat
 Calm
 Anxious

SUPPORTS:
 Lives with others
 Lives alone
 Gets help from others

ELIMINATION:
BLADDER:
BOWEL:
 Continent
 Incontinent
 Retention
 Frequency
 Dribbling

TOILETING:
 Continent
 Incontinent
 Constipation
 Diarrhea
 Last BM: _____

 Independent

 Dependent

 Ostomy

Type: _____

Appliance: _____

 Toilet

 Bedpan

 Catheter

 Foley

 Urostomy

SKIN:

 Skin Intact Yes No

Describe any impairments:

Size: _____ Site: _____ Drainage: _____

HYGIENE / MOBILITY:

Used:

Oral Care:	<input type="radio"/> Independent	<input type="radio"/> Assist	<input type="radio"/> Total Dependent	_____
Bathing:	<input type="radio"/> Independent	<input type="radio"/> Assist	<input type="radio"/> Total Dependent	_____
Dressing:	<input type="radio"/> Independent	<input type="radio"/> Assist	<input type="radio"/> Total Dependent	_____
Wheelchair:	<input type="radio"/> Independent	<input type="radio"/> Assist	<input type="radio"/> Total Dependent	_____
Transfer:	<input type="radio"/> Independent	<input type="radio"/> Assist	<input type="radio"/> Total Dependent	_____
Ambulation:	<input type="radio"/> Independent	<input type="radio"/> Assist	<input type="radio"/> Total Dependent	_____
<input type="radio"/> Amputation	<input type="radio"/> Contractures	<input type="radio"/> Paralysis	<input type="radio"/> Paresis	<input type="radio"/> Other _____

Equipment / # Persons

SAFETY:
 Fainting Dizziness Headaches Seizures Weakness

Signature: _____ Date: _____

ALL AREAS MUST BE COMPLETED