Triangle Cross Ranch Pre- Admission Assessment

Please fill out all of the following forms and return to the Triangle Cross Ranch Executive Director. Please be as complete and as accurate as possible. Attach copies of all documents required.

Full disclosure of all previous assessments, diagnoses, treatments, medications, placements, behaviors and health care information is required prior to placement evaluation. You may be asked to provide additional information during the application and evaluation process. Refusal to provide requested information, or withholding information, will end the placement evaluation.

If you have any questions during this process, please call the Executive Director at 970-454-2219.

The individual identified below has applied for Admission to Triangle Cross Ranch:

Name _______________________________________DOB ____________SSN# ________________

Current Address ____

____

____

Telephone number _______________________________________

The Colorado Department of Public Health and Environment requires that we complete an assessment of each applicant upon admission and periodically thereafter.

Your opinions are important to us.

As a necessary part of the assessment process we ask that you assist us by reviewing or completing the following questionnaire, identifying or adding any information you feel is necessary.

This assessment must be complete and in the possession of the Executive Director prior to any consideration for any type of residency or respite care.

Thank you for your cooperation and support.

Application and Pre-Admission Checklist

Each applicant shall have the following items in place prior to consideration for the 10 day trial period or respite care.

- Complete application
- Documentation from prior placements and all requested documentation concerning behavioral or medical disclosures
- Psychiatric assessment
- Primary diagnosis or secondary diagnosis of mild retardation or brain injury
- Physical assessment
- Complete and current medication list including hard copies of current doctor’s orders or prescriptions
- Prescription for a therapeutic diet, prescribed within one calendar year of application
- Exercise directives approved by physician or exercise specialist within one calendar year of application
- Hearing assessment
- Vision assessment
- Provider packet signed and notarized
- Court appointed guardianship papers
- Medical power of attorney papers
- Policy disclosures signed and notarized
- PWS agreements signed and notarized
- Release of Liability signed and notarized
- Co-payment Guaranty Agreement signed and notarized
- Release of Background Information
- Legal/Advance Directives Disclosures
- Authorization to Release Health Care Information signed and dated for each provider
- Initial care plan

The Director, in conjunction with other staff members and appropriate health care professionals shall review the provided information for a period of not less than 7 days before notification of acceptance or denial of the 10 day trial period is made. During this review phase, additional information and releases of additional documentation may be requested by the Director. No applicant shall begin their trial period prior to such a review process.

Application for Pre-Admission

Applicant Name _______________________________ Date of this application ____________________

DOB ______________ SSN#___________________ Age ____________ M/F

Primary Diagnosis _________________________ Secondary Diagnosis ______________________

Current Address ____ Phone _____________________

____

Legal Guardian/Responsible Party ____

Address ____ Phone _____________________

____

Relationship to Applicant ____

Emergency Contact (if different from above) ____

Phone ____

Relationship to applicant ________________________________

Social Worker/Advocate ___________________________________ Phone _____________________

Physical description

Height __________________Weight __________________ Hair ______________ Eyes _____________

Identifying marks or characteristics ____

____

Family Background

Father ____ Living? _____________________

Address ____ Phone _____________________

____

Email address _____________________________________

Marital status _______________

Mother ____ Living? _____________________

Address ____ Phone _____________________

____ Marital status _______________

Email address _____________________________________

Siblings (include names, ages and addresses.)

Name	Age	Address
____	___________	____________________________
____	___________	____________________________
____	___________	____________________________
____	___________	____________________________
____	___________	____________________________

Others in household

____	___________	____________________________
____	___________	____________________________
____	___________	____________________________

Current Living Situation

______With parent or guardian

______ Independently

______Placement

- ______Host home
- ______Group home
- ______Assisted living
- ______Intermediate care facility
- ______Specialized placement (describe
- ______Long term care facility

Please give the names and addresses of all previous placements in reverse order, beginning with the current placement.

____

____

____

____

____

____

____

____

Is this individual currently employed? ______ Where? ____________________________________

Address ____________________________________

____

Phone ____________________________________

Supervisor __________________________________

Does this individual qualify for employment? Why or why not? ______________________________

____

Health Care Provider(s) (Please list all. Use additional sheets if necessary.)

Name	Address	Phone
________________________________	______________________________________	______________
________________________________	______________________________________	______________
________________________________	______________________________________	______________
________________________________	______________________________________	______________
________________________________	______________________________________	______________
________________________________	______________________________________	______________
________________________________	______________________________________	______________
________________________________	______________________________________	______________
________________________________	______________________________________	______________

Support programs ____

Name of the person filling out this application ____

Address ____Phone ______________________

Relationship to applicant ____

Personal Assessment

Name ________________________________DOB _______________ SSN# ______________________

Please list and describe all current medical concerns or health care issues.

____

____

____

____

Please list all current medications.

____

____

____

Please list all allergies, including medication allergies.

____

____

____

Please list and describe special medical treatments that you currently must carry out.

____

____

____

List all medical equipment currently in use.

____

____

____

____

____

____

Please give an accounting of the all visits to a physician within the last year, including the reasons for the visits and the treatments or results. Use additional paper if necessary or attach appointment forms.

____

____

____

How would you best describe the individual's behavior and/or mental status?

Alert – Awake and aware
Oriented – knows person, place, time
Confused/disoriented – does not know person, place, time
Cooperative – gets along well with others, follows directions and physician's orders
Uncooperative
Lonely/depressed
Withdrawn – just wants to left alone
Combative – strikes out against others at times
Wanders – at risk for getting lost due to forgetting
Flight risk – deals with stress by running away, refuses to stay on the property

Other special behavior concerns ____

____

____

____

To the best of your knowledge, could this individual function free of supervision or assistance in a room at this facility? Please state reasons why or why not.

____

____

____

Does this individual qualify for employment off of the facility? Please list the last 5 years of previous employment.

____

____

____

Please check the activities that would interest this individual:

Arts/Crafts	Men's/Women's Groups
Bingo	Outings/Trips
Card games	Senior Center visits
Children/kids	Music/Radio
Church/spiritual	Books/Reading
Cleaning	Rancher Council
Cooking/Baking	Shopping
Dancing	Sports/Sports TV
Exercise	Travel
Games/group games/video	TV/Movies
Gardening	Volunteering
Group activities	Visits with family and friends
Animal interaction	Writing
Music	Parties/Socials

Please list the household chores that this individual enjoys and/or has experience in doing.

____

____

____

Please list the household chores that this individual dislikes and/or is restricted from doing. Please describe reasons for the restrictions.

____

____

____

Please describe other activity suggestions and/or concerns.

____

____

____

Please check the items for which this individual requires assistance and provide an explanation for the items that require assistance.

_____Bathing/showering____

_____Dressing____

_____Elimination____

_____Continent _____Incontinent

_____Hair/Nail care____

_____Shaving____

_____Oral care _____Dentures

_____Has own teeth

____

_____Skin care____

_____Sleep/rest/waking____

_____Mobility Gait Steady

Needs adaptive device

Gait unsteady

____

Nutritional:

Physician prescribed therapeutic diet ____

Food preferences ____

____

____

Food dislikes ____

____

____

Monitor or encourage food/fluid intake? Explain. ____

____

____

____

Sensory:

Please check the items for which the individual has a demonstrated impairment, along with a brief explanation of the impairment and treatments or accommodations for this.

_____Vision ____

_____Hearing ____

_____Speech ____

_____Smell ____

_____Taste ____

_____Touch ____

Applicant Signature ____ Date ______________

Legal Guardian Signature ____________________________________ Date ______________

Other Signature ____ Date ______________

Relationship to applicant ____________________________________

Executive Director Signature _________________________________ Date ______________

Informal Hearing Handicap Index

This is an informal assessment to be filled out by family or staff. Please rate the individual on the following scale.

5 = very often 1 = almost never

Rancher's Name ____Date ________________

When this person is with other people, does s/he need to hear better?
5 4 3 2 1

Do staff, family, or friends make negative comments about this person's hearing?
5 4 3 2 1

Does this individual have trouble hearing others if there is a radio or TV playing in the same room?
5 4 3 2 1

Does this individual have trouble hearing the radio or TV?
5 4 3 2 1

How often do you feel this individual's life would be better if s/he could hear better?
5 4 3 2 1

How often is this person embarrassed because s/he does not hear well?
5 4 3 2 1

When the individual is alone, does s/he need to hear better?
5 4 3 2 1

Do people tend to leave this person out of conversations because s/he does not hear well?
5 4 3 2 1

Do people tend to leave this person out of conversations because s/he does not hear well?
5 4 3 2 1

In your opinion, how often does this individual withdraw from social activities (in which s/he ought to participate) because s/he does not hear well?
5 4 3 2 1

Does this individual say "What?" or "Pardon me?" or fail to answer when people first speak to him or her?
5 4 3 2 1

Physician's Examination

A physician must fill out this form for routine physical exam or provide an in-office form that provides *all* of the following information.

General Data

Name________________________________DOB___________Age___________Sex_____

Physician ____Chart No.____________

Measurements

Temp _____________Height ______________Weight __________Respirations __________

Blood Pressure _________Systolic __________Diastolic__________ Pulse ______________

Distance Vision: Right 20/____ Corrected to 20/____ Hearing: Right _________

Left 20/____ Corrected to 20/____ Left __________

Findings

Normal Abnormal Comments/Observations

Head, face, neck, scalp ____

Mouth & throat ____

Ears – internal & external canals ____

Tympanic membranes ____

Eyes – general ____

Ophthalmoscopic ____

Pupils (motility) ____

Ocular (motility) ____

Lungs & chest ____

Breast ____

Heart ____

Vascular system ____

	Normal	Abnormal	Comments/observations

Abdomen &viscera ____

Anus & rectum ____

Endocrine system ____

Genital-urinary system ____

Upper extremities ____

Lower extremities ____

Feet ____

Spine & musculoskeletal ____

Identifying body marks ____

Skin, lymphatics ____

Neurologic ____

Females: Pelvic ____

Pap Smear ____

Diagnosis ____

Summary

____

____

____

Surgeries

____

____

____

Hospitalization/institutionalizations

____

Medications
Attach a list all current prescribed medications & OTC medications. You may use the attached form or an in-office form. All medications including OTC's, PRN's and Vitamins REQUIRE a physician's prescription and hard copies of all medications must be attached.

Is the individual able to self-administer medication?   Yes   No

What assistance is needed? ____

Please attach a doctor's order for self-administration of medication if applicable.

Immunizations – *Please attach the most recent copy of the individual's immunization record.*

Date of last tetanus shot ________________

Blood work:

Hepatitis C ________________ HIV ______________ Other ______________

Please attach copies of the latest blood screenings.

Date of last TB test ____________________   Pos/Neg _______________________

Diet restrictions – Please attach a copy of a doctor's order for a therapeutic diet or diet restrictions.
All diet restrictions must have a doctor's order.

Allergies ____

Physical or mental limitations/restrictions on activity ____

____

I have examined ____ and found him/her to be in good health and free from communicable disease.

____   ____
Physician Name/Title   Physician's Signature

Date ____________________________________

Developmental Disability Assessment Snapshot

A physician and other health professional must fill out this form and/or provide an alternate form from the professional's office that addresses each of the following areas. Please include all contact information for the assessing health professionals. Complete assessment profiles must be attached.

1. IQ and Psychological tests.

   IQ: ______________________________ Date tested _________________________

   Test used: ____

2. Psychological test results:

   ____

   ____

3. Psychological diagnosis if any:

   ____

   ____

4. Primary diagnosis of developmental disability

   ____

   ____

5. Secondary diagnosis

   ____

   ____

6. Additional diagnoses

   ____

   ____

7. Etiology and dates of disability

   ____

   ____

8. Suggested treatment and management of disability

   ____

   ____

9. Limitations and restrictions of disability

____

____

Physician Name ___________________________Signature ________________________________

Address_________________________________ Telephone ______________________

____

____

Psychiatrist Name _________________________Signature ________________________________

Address _________________________________ Telephone ______________________

____

____

Legal Guardian/Parent Signature ____

Medication List

Please provide a complete list of all prescription medications and all over-the-counter (non-prescription) medications (vitamins, antacids, cold medicines, pain relievers, topical preparations, etc.)

Please attach hard copies of all physicians' orders and prescriptions for all medications. All orders must include the date of the order and a doctor's signature.

Rancher Name ____ Date _____________________

Physician's Name ____ Date _____________________

Address ____ Phone _____________________

Medication/Reason	Dosage	Frequency	Date	Change

Prescription for a Therapeutic Diet

____ has been prescribed the following therapeutic diet, specific to his/her diagnosis of Prader-Willi Syndrome.

- Restrict access to food via locking devices and alerts.

- ____________________________ calorie limit per day.

- ____________________________ daily incentive calories allowed based on adherence to the attached exercise program.

- ___________This diet constitutes a weight loss diet.
- ___________This diet constitutes a weight maintenance diet.

The ideal weight/target weight for this individual is ____.

Professional follow up to be conducted every ____________weeks/months.

____ ___________________________

Prescribing Physician

Approved Exercise Program

The following exercise program has been designed for ______________________________________ and is specific to his/her diagnosis of Prader-Willi Syndrome.

Please describe below in detail the daily activities as well as any incentives that may be offered for completing the program on a daily basis.

Professional follow up shall be conducted every ____________________weeks/months.

____ ____________________

Professional approving program Title Date

Release of Background Information

All current and prospective Ranchers, staff and volunteers are subject to an annual criminal history record check. Our review of your records may include the following:

Criminal record
Driving record
Character references
Employment references
Social Security number
Employment verification
Education records

By signing and providing the information requested, you acknowledge and agree to allow Triangle Cross Ranch to obtain, verify and review the information you've provided as well as information in the records accessed as the result of the background and reference information checks. If after reviewing the information received, Triangle Cross Ranch determines that some of the data adversely affects your status here, you will be given a "pre-adverse action disclosure" that includes a copy of the report and an explanation of the law. You will also be given an "adverse action notice" that will contain the name, address and phone number of the background check company we used; a statement that the company we used did not make the adverse decision, rather that the Triangle Cross Ranch Board of Director did. You will also receive notice that you have the right to dispute the accuracy or completeness of any of the information received.

Please provide the following information so that we may accurately submit our requests for information.

Printed name: ____

Maiden name: ____

Social Security number: ____

Date of Birth: ____

Signature: ____

Today's Date: ____

Legal/Advance Directives Disclosures

Rancher Name: ____ Date: _____________________

Please identify the legal arrangements that have been made on behalf of the above named individual:

________Court Appointed Guardianship

________Guardianship ad litem

________Financial Conservatorship

________Living will

________Medical Durable Power of Attorney

________Medical Proxy

________DNR Directive

Please attach copies of all legal documentation for the above named items. Triangle Cross Ranch cannot recognize the legal authority of these arrangements without proper documents to back them up.

Signatures of individuals who completed this form:

Rancher's Signature: ____ Date: _______________

Legal Guardian: ____ Date: _______________

Parent/Responsible Party: ____ Date: _______________

Other Signature: ____ Date: _______________

Relationship to Rancher: _______________________________________ Date: _______________

Executive Director: ____ Date: _______________

Media Release

From time to time we have the opportunity to use pictures of the Ranch and Ranchers for our website, brochures, newspaper articles and other forms of advertising. Only first names or no names are used in captions. We wish to always follow the direction of the Ranchers and their guardians. Therefore, please complete the attached form that will become part of the Rancher's file.

___________Yes, you have my permission as Rancher/Legal Guardian to use photos of

_______________________ for purposes of promoting the Ranch and Ranch activities.

___________No, do not use photos of _________________________________ for any Ranch

promotional materials.

Rancher signature ____ Date _________________

Legal Guardian signature ____________________________________ Date _________________

Authorization to Release Health Care Information

Please make as many copies as necessary. Each facility or provider will require a signed copy.

Patient's Name ____Date of Birth ____________________

Previous Name ____SSN# ___________________________

I request and authorize ____
to release health care information of the patient named above to

Facility ____

Address ____

City _________________________State ______Zip _____________

This request and authorization applies to:

______ Health care information relating to the following treatment, condition, circumstances or dates:
____

______ All health care information

______ Other ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV, AIDS and gonorrhea.

______ I authorize the release of my STD results, HIV/AIDA testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

______ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient signature ____ Date ___________________

Legal guardian ____ Date ___________________

Other signature ____ Date ___________________

Relationship to patient ____

Individualized Care Plan Goals and Objectives

This form is the first step in developing an individualized care plan for the applicant. It is for the family and applicant to use together in clarifying the primary reasons for placing their family member at Triangle Cross Ranch and visualizing their expectations of the Ranch staff.

Please identify the behaviors and/or results you would like to see related to residency at Triangle Cross Ranch and participation in its programs. Staff will help with this process if you find it difficult.

Rancher Date

Goal

____

____

____

Objective

____

Objective:

____

Objective

____

Staff Support

____

Evaluation

____

____