

**VALLEY CARES**  
**Application Addendum for Assisted Living**

Date: \_\_\_\_\_

NAME: \_\_\_\_\_

Reason for application/recent history: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

Other providers/caregivers: \_\_\_\_\_ Phone: \_\_\_\_\_

Other providers/caregivers: \_\_\_\_\_ Phone: \_\_\_\_\_

Other providers/caregivers: \_\_\_\_\_ Phone: \_\_\_\_\_

By signing below I give permission for the above individuals to share medical and functional information with West River Valley Assisted Living staff .

Applicant (or representative) Signature \_\_\_\_\_ date \_\_\_\_\_

**Medical History/Diagnoses:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mental Status/Behavior:**

\_\_\_ Alert and oriented      \_\_\_ Short term memory loss      \_\_\_ Periodic confusion  
\_\_\_ Long term memory loss      \_\_\_ Withdrawn      \_\_\_ Enjoys social activities  
\_\_\_ Wanders      \_\_\_ Sun-downing behavior      \_\_\_ Agitated, anxious

Please add any other information you think is important: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Insurance Information

Medicare: \_\_\_ A \_\_\_ B Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Medicaid: ID Number: \_\_\_\_\_

Community Medicaid

Long Term Care Medicaid (Choices for Care) Case worker: \_\_\_\_\_

Medicare Part D (Pharmacy Insurance) \_\_\_\_\_

Other Insurance: \_\_\_\_\_

## Activities of Daily Living

We can provide assistance with most needs. Please check appropriate level of care.

- 1) Dressing upper body  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 2) Dressing lower body  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 3) Grooming (*Combing your hair, putting on makeup or shaving, and brushing teeth*)  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 4) Bathing (*Includes running water, getting in and out of tub/shower, washing all body parts*)  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 5) Eating (*includes cutting your own food, feeding self*)  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 6) Bed Mobility (*How well can you manage sitting up or moving around in bed?*)  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 7) Transferring (*How well can you move in and out of a bed or chair?*)  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 8) Toileting (*Includes adjusting your clothing, getting on and off toilet, and cleaning yourself*)  
Independent    Supervision/Cueing   Some Assistance   Dependent  
If incontinent, how much help do you need to manage with changing pads, cleaning yourself, etc.  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 9) Climbing Stairs (*One flight of stairs*)  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 10) Specify assistive device needed for mobility: \_\_\_\_\_  
Mobility (*How well can you move \*within the home, not including stairs?*)  
Independent    Supervision/Cueing   Some Assistance   Dependent  
  
Mobility (*How well do you manage about 100 yards or a block \*outside the home?*)  
Independent    Supervision/Cueing   Some Assistance   Dependent
- 11) Managing medications:  
Independent    Supervision/Cueing   Some Assistance   Dependent  
Please explain: \_\_\_\_\_

Please note that all information in this application is kept completely confidential and is used only by our staff for the purpose of assessing the appropriateness of your moving to Valley Cares.

If you have any questions, please contact Catherine Amarante RN, Care Director, at (802) 365-7190 ext 102.