ADMISSION QUALIFICATIONS AND DISCLOSURES

Thank you for applying to the Veterans Home of California. Please follow the instructions provided to begin the application process. If a spouse or domestic partner is also applying please submit a separate application.

QUALIFICATIONS FOR ADMISSION CA MVC §1012:

1. You are at least age 55, or disabled, or homeless.
2. You served in the U.S. Armed Forces and you were discharged or released from active duty under conditions other than dishonorable and are eligible for health care benefits, hospitalization or domiciliary care in a veterans' facility in accordance with the rules and regulations of the U.S. Department of veterans Affairs.
3. You meet the qualifications for a non-veteran spouse or domestic partner.
4. You are a California resident.
5. You are able to live with and get along with other people in a structured communal environment.
6. As a condition of entering and to continue to reside in a Veterans Home, the applicant / member shall:
   (a) Obtain and maintain Medicare A, B, and D enrollment, if eligible.
   (b) Obtain and maintain Medi-Cal enrollment, if eligible.
   (c) If not eligible for Medicare and Medi-Cal, the applicant / member must obtain and maintain other basic medical insurance policy/policies as required by Military and Veterans Code 1033(c).
   (d) Obtain and maintain United States Department of Veterans Affairs health care program enrollment, if eligible.

DISCLOSURES: UNREIMBURSED COST OF CARE CA MVC §1035 – §1035.7

Upon admission the administrator shall provide written notice to the veteran informing him or her of costs of care that may be incurred in excess of the member contribution fee. The applicant is encouraged to seek counsel from a legal expert to protect his or her assets.

CA MVC §1035.5 (b)

Every veteran applying for membership in the home on or after January 1, 1984 shall be furnished a written explanation of the limitations and restrictions on the right to dispose of money and personal property contained in Sections 1035 to 1035.4, inclusive.

For more information go to www.calvet.ca.gov then click on Vet Homes.

TABLE OF CONTENTS AND INSTRUCTIONS

Please see page A-9 of this application if you need assistance in completing the application or if you have any questions.

This application package has three sections. All responses in each section are required.

Section		Completed By
A	**General Information**	**Applicant**
B	**Resident / Patient Health Information**	**Applicant**
C	**Physician's Medical Certificate**	**Physician**

INSTRUCTIONS

CalVet recommends you take the following steps if you wish to expedite the admissions process:

1. Complete sections A & B of the application.
2. Contact your physician as soon as possible for an exam and to complete Section C. This section is only valid for 6 months.
3. To verify appropriate placement in any veterans home, current medical records must be reviewed.
   a. Obtain the most recent 12 months of Medical Records:
      - To expedite the process you may provide the "Authorization for Release of Information" in Section B to your medical providers and forward your records to the home; or
      - You may provide copies of the "Authorization for Release of Information" in Section B to the home: One for each medical provider / facility. The time required to obtain your medical records may delay your application process.
4. Copies of current Advanced Directives, Durable Power of Attorney (DPOA), and / or Physician Orders for Life-Sustaining Treatment (POLST) form are encouraged prior to admission.
5. Completed application packages must include all required documents. This includes, but is not limited to the:

   Form DD-214: Certificate of Active Duty Discharge; Proof of California residency; and proof of health insurance; and all applicable documents listed on the "DOCUMENT CHECKLIST" found on page iii.

TABLE OF CONTENTS AND INSTRUCTIONS

DOCUMENT CHECKLIST: Applicant must supply the following documents, if applicable, or admission may be delayed.

	Documents To Include With Application	✓	**N/A**
1.	IDENTIFICATION		
	a. Form DD-214: Certificate of Active Duty Discharge		
	b. Birth Certificate		
	c. DMV Driver's License / Identification Card		
	d. Social Security Card		
	e. Proof of California Residency (see section A-1)		
2.	INCOME (provide addition information as appropriate)		
	a. Bank Statements (most recent)		
	b. Tax Returns, State and Federal (Latest)		
	c. IRS Forms, W-2 or 1099 (Latest)		
3.	MEDICAL INSURANCE – Copy of front and back of valid card		
	a. Medi-Cal Card		
	b. Medicare Card		
	c. VA Medical Card		
	d. Dental or Other Insurance Card		
4.	LEGAL / OFFICIAL PAPERS		
	a. Advanced Directives, POLST		
	b. Power of Attorney and/or DPOA		
	c. Marriage Certificate (if currently married)		
	d. Court Ordered Monthly Payments (spousal/child support)		
	e. Final Divorce Decree (if applicable)		
	f. Life Insurance Policy		
	g. Pre-Arranged Burial Plan		
	h. Will or Trust		

GENERAL INFORMATION

A

PERSONAL INFORMATION

Full name _____
Last First Middle

Social Security number _____ Date of birth _____

Driver license number _____ State _____

Home address _____
Street City State Zip Code

Mailing address _____

Applicant phone _____ Cell phone _____

Place of birth _____

Are you: □ Male □ Female □ Non binary

Are you a veteran? □ Yes □ No

MARITAL STATUS

Marital status: □ Single □ Married □ Divorced □ Widow / Widower

If currently married or in a domestic partner relationship answer the following:

Date of marriage to your current spouse: _____

Is your spouse or domestic partner a veteran? □ Yes □ No

Is your spouse or domestic partner also applying for admission to a Veterans Home? □ Yes □ No

Spouse / Domestic partner - full name _____
Last First Middle

CALIFORNIA RESIDENCY

Are you a current resident of the State of California □ Yes □ No

For proof of residency I have included a copy of (please check one or more):

□ Valid California Driver's License
□ California Department of Motor Vehicle (DMV) Identification Card
□ Registered Voter Status
□ Utility Bill that shows the applicant's residence
□ Paying California State Income Taxes as a resident
□ Letter from County Veteran Service Officer or a VA representative
□ Other: Explain: _____

GENERAL INFORMATION

A

MILITARY SERVICE INFORMATION

If during your military service your name was different than the name listed on page A-1 of this application, enter it below.

Name used _____

Last First Middle

Select your Branch / Branches of Service:

- ☐ Air Force
- ☐ Army
- ☐ Coast Guard
- ☐ Marines
- ☐ Navy
- ☐ Air Force Reserve
- ☐ Air National Guard
- ☐ Army National Guard
- ☐ Army Reserve
- ☐ Coast Guard Reserve
- ☐ Marines Reserve
- ☐ Navy Reserve

Enter your Service Dates and Information below:

	Branch	Service Number	Service Dates From	Service Dates To	Discharge Type
1.					
2.					
3.					

Are you retired from the military? ☐ Yes ☐ No

Are you a Medal of Honor recipient? ☐ Yes ☐ No

Are you a former POW? ☐ Yes ☐ No

Are you the spouse or the surviving spouse of a Medal of Honor recipient or former POW? ☐ Yes ☐ No

Are you a Purple Heart recipient? ☐ Yes ☐ No

GENERAL INFORMATION

A

VETERAN'S BENEFITS INFORMATION

Have you ever applied for U.S. Department of Veterans Affairs (VA) benefits?
□ Yes □ No List your VA claim number, if known. _____

Do you have any Service-Connected (SC) disabilities? □ Yes □ No

If yes, please provide award letter listing your service-connected disabilities:

- Percentage of SC disability: _____%

  List service connected disability related diagnosis below:

_____ _____ _____

Are you, your spouse, or legal dependent applying for / receiving U.S. Department of Veterans Affairs (VA) Aid & Attendance benefits?
□ Yes □ No

APPLICANT'S FINANCIAL INFORMATION

Applicants must disclose income and assets with supporting documentation per California Military and Veterans Code (MVC) §1012.1.

INCOME: List all income sources and amounts for you and your spouse / domestic partner and provide documentation.	**Self**	**Spouse / Domestic Partner**
Social Security	$	$
Supplemental Security Income* *(*SSI may be discontinued upon admission)*	$	$
Disability payments other than SSI or V.A.	$	$
V.A. Non-Service Connected Pension	$	$
V.A. Aid and Attendance	$	$
V.A. Service-Connected Compensation	$	$
Civil Service Retirement (Annuity number _____)	$	$
Military Retirement	$	$
Railroad Retirement (Number _____)	$	$
Other Retirement / Pension / Annuities	$	$

GENERAL INFORMATION

A

Dividends / Bank Interest / Investment Income	$	$
Wages / Salary / Bonuses / Commissions (Net)	$	$
Workers' Compensation Payments	$	$
Rental Income	$	$
Other Income, Spousal Support Received, etc.	$	$
SUBTOTAL	$	$

TOTAL MONTHLY INCOME **$**

OTHER INCOME OR SUPPORT: List all annual income from sources not previously listed within the current tax year.	**Self**	**Spouse / Domestic Partner**
Cash Gifts in excess of $1000.00	$	$
Life Insurance Benefits *(12 CCR §506)*	$	$
Property Sale Proceeds	$	$
Cash Inheritance in excess of $1000.00	$	$
Cash converted from Inherited Assets	$	$
Gambling and Lottery Winnings	$	$
SUBTOTAL	$	$

SUM OF ADDITIONAL ANNUAL INCOME **$**

ASSETS – List current values, balances, and individual / joint status.		**Self**	**Spouse / Domestic Partner**
Real Estate		$	$
Securities		$	$
Stocks		$	$
Bonds		$	$
Vehicle(s)		$	$

GENERAL INFORMATION

A

BANKING	Balance	Individual	Joint	Bank Name
Checking	$			
Savings	$			
Other Bank	$			
Other Bank	$			

INCOME OFFSET / SUPPORT: Financial support the applicant is required to pay.

FAMILY SUPPORT- Check if you are contributing to the support of:

Spouse _____ Child _____ Parent _____

If checked list monthly amount $_____

COURT ORDERED SUPPORT- Are you under a court order to provide former spouse, dependent, or other support or restitution?

□ Yes □ No If yes, list monthly amount $_____

INSURANCE: Check all active insurances & enter policy number & premium amount.	**Policy Number**	**Premium Amount**
□ Medicare (Select coverages)		
__ Part A (only)	_____	$_____
__ Part A / B	_____	$_____
__ HMO (Name_____)	_____	$_____
__ Part D	_____	$_____
□ Medi-Cal Program (Medicaid)	_____	$_____
□ Federal VA Medical Program	_____	$_____
□ Tricare Insurance	_____	$_____
□ Supplemental Insurance Plan	_____	$_____
□ Dental Insurance	_____	$_____
□ Vision Insurance	_____	$_____
□ Long-Term Care Insurance	_____	$_____
□ Other Plan _____	_____	$_____

CRIMINAL BACKGROUND INFORMATION

Prior to acceptance a Department of Justice and / or Federal Bureau of Investigation criminal background check and California's Megan's Law website registered offender status verification may be conducted.

Convictions: Have you ever had any criminal convictions? □ Yes □ No

If yes, provide the following:

Conviction Date: _____

Describe Conviction: _____

_____

County: _____ State: _____

Pending Charges: Do you have any criminal charges pending?

□ Yes □ No If yes, describe:

_____

Probation / Parole: Are you currently on probation or parole? □ Yes □ No

If yes, provide your probation / parole officer information:

Name: _____

Address: _____

City State Zip Code

Telephone: _____ County: _____

Mandated Law Enforcement Registration: Are you required by law to register with law enforcement? □ Yes □ No

If yes, where are you currently registered?

County: _____ State: _____

MEDICAL INFORMATION

Have you received any medical, psychiatric, alcohol or drug treatment by any medical provider or facility in the past 12- months? □ Yes □ No

If yes, please list below, *use additional paper, as necessary. Additional information or records may be requested.*

Facility / Physician Name: _____

Address: _____
Street Address City State Zip Code

Last date(s) of treatment: _____

Facility / Physician Name: _____

Address: _____
Street Address City State Zip Code

Last date(s) of treatment: _____

Facility / Physician Name: _____

Address: _____
Street Address City State Zip Code

Last date(s) of treatment: _____

Facility / Physician Name: _____

Address: _____
Street Address City State Zip Code

Last date(s) of treatment: _____

Facility / Physician Name: _____

Address: _____
Street Address City State Zip Code

Last date(s) of treatment: _____

GENERAL INFORMATION

A

VETERANS HOME RESIDENCY

Prior State Home Residency: Have you ever lived in any state Veterans Home? □ Yes □ No If yes, provided the following information:

Facility Name: _____

Facility Address: _____

Date Admitted: _____ Date Discharged: _____

(Month / Year) *(Month / Year)*

Comments (add additional sheets if needed): _____

_____

_____

_____

CalVet has eight (8) Veterans Homes listed below. Select your preference for the Homes(s) you are applying to. Mark "1" for your first choice, "2" for your second choice, and so on. If you are not interested in a specific Home, mark an "X" next to "I do not wish to apply for this location."

Your completed application and required records should be submitted to your first choice Veterans Home. If you decide to revise your order of priority simply contact the Home and request they forward your application and required information to your new preferred Home.

LOCATION	ORDER OF PREFERENCE	CHECK IF NOT INTERESTED IN A LOCATION
Barstow	#_____	___ Not interested in this location
Chula Vista	#_____	___ Not interested in this location
Fresno	#_____	___ Not interested in this location
Lancaster	#_____	___ Not interested in this location
Redding	#_____	___ Not interested in this location
Ventura	#_____	___ Not interested in this location
West Los Angeles	#_____	___ Not interested in this location
Yountville	#_____	___ Not interested in this location

GENERAL INFORMATION

A

APPLICATION ASSISTANCE

If you would like help filling out your application or have any questions contact the preferred site:

LOCATION	TELEPHONE	TOLL FREE	FAX NUMBER
Barstow	760-252-6281	800-746-0606	760-252-6379
Chula Vista	619-482-6010	888-857-2146	619-205-1110
Fresno	559-493-4224	855-769-5792	559-493-4270
Lancaster	661-974-8141	888-272-6030	661-974-8198
Redding	530-224-3800	855-769-5791	530-222-7599
Ventura	805-659-7502	888-272-2104	805-659-7559
West Los Angeles	424-832-8202	877-605-1332	424-832-8205
Yountville	707-944-4601	800-404-8387	707-948-2525

APPLICATION SIGNATURE

Original signatures are required on the application. If your application is submitted via fax please keep your original document and supply it to the home at or before the time of your admission.

SIGNATURE _____ DATE _____

AUTHORIZATION FOR RELEASE OF INFORMATION

B

Please provide one copy per medical provider or healthcare facility request.

Your Information		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:

Health Care Organization Providing the Information	Veterans Home to Receive the Information
Name: _____ Position or Role: _____ Address: _____ City/State/Zip: _____ Phone # : (_____)_____ _____ Fax #: (_____)_____ _____	Name: _____ Position or Role: ___(ADMISSIONS UNIT)_____ Address: _____ City/State/Zip: _____ Phone # : (_____)_____ _____ Fax #: (_____)_____ _____
45 C.F.R. §§164.508(c)(1)(ii), and (iii); CA Civil Code §§56.11(e) and (f)	

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)
45 C.F.R. §164.508(c)(1)(i); CA Civil Code §§56.11(d), and (g)

Check each type of confidential information you authorize to be released:

- ☐ HIV or AIDS Information
- ☐ Alcohol/Drug Information
- ☐ Mental Health/Behavioral Health Information
- ☐ Genetic Testing

Other: All Medical, Psychiatric, Drug and Alcohol, HIV Tests and any other pertinent information that may be needed to determine appropriate admissions eligibility.

For the following dates: from _____ to_____ .

Description of the Purpose and Limitations for the Use or Release of the Information (Indicate how information will be used)
45 C.F.R. §164.508(c)(1)(iv); CA Civil Code 56.11(g)

To determine admissions eligibility to the Veterans Home of California.

The information will not be used for any purpose other than its intended use.

Will the health plan or provider receive money for the release of this information? ***45 C.F.R. §164.524(c)(4)***

☐ Yes ☐ No

Reasonable fees may be charged to cover the costs of copying and postage.

AUTHORIZATION FOR RELEASE OF INFORMATION

B

This authorization for release of the above information to the above named persons or organizations will expire one year from the date of the application: _____ (date). *[45 C.F.R. §164.508(c)(v); CA Civil Code §56.11(h)]*

I understand that:

- I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. *[45 C.F.R. §164.508(c)(2)(i)]*
- I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to the Admissions Department at the specific Veterans Home of California to which I applied. The authorization will cease on the date my valid revocation request is received. *[45 C.F.R. §164.508(c)(2)(i); CA Civil Code §56.15]*
- The Notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and includes limitations on my revocation. *[45 C.F.R. §164.508(c)(2)(i)]*
- My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this authorization. *[45 C.F.R. §164.508(c)(2)(ii)]*
- Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. *[CA Civil Code §56.13]*
- If the organization or person I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. *[45 C.F.R. §164.508(c)(2)(iii)]*
- I have the right to receive a copy of this authorization. *[45 C.F.R. §164.508(c)(4); CA Civil Code §56.11(i)]*
- Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes. *[CA Civil Code §56.104(a)(4)]*

Patient Signature:	Date:

[45 C.F.R. §164.508(c)(1)(vi); CA Civil. Code §56.11(c)]

Patient's (Personal) Representative Signature:	Relationship:	Date:

[45 C.F.R. §164.508(c)(1)(vi); CA Civil Code §56.11(c)]

PHYSICIAN'S MEDICAL CERTIFICATE

C

INSTRUCTIONS

This section is to be completed by a physician and is used to assess the health care needs of the applicant.

1. **Print Admission Application Section C – "Physician's Medical Certificate"**
2. **Submit to your primary care physician.**
3. **Return the completed document to the Veterans Home processing your admission application.**

THIS CERTIFICATION IS VALID FOR SIX MONTHS

ALL INFORMATION MUST BE *CURRENT AND COMPLETE*

TO AVOID DELAYS IN PROCESSING YOUR PATIENT'S APPLICATION

PHYSICIAN'S REPORT FOR ADMISSION

I. FACILTY INFORMATION

1. FACILITY NAME

2. FACILITY ADDRESS CITY ZIP CODE

3. LICENSEE'S NAME / FACILITY LICENSE NUMBER	4. FACILITY TELEPHONE
California Department of Veterans Affairs	( )

II. RESIDENT INFORMATION *To be completed by the resident / resident's legal representative)*

1. NAME	2. BIRTH DATE	3. AGE

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(To be completed by resident / resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above

1. SIGNATURE OF RESIDENT AND / OR RESIDENT'S LEGAL REPRESENTATIVE

2. ADDRESS	3. DATE

IV. PATIENT'S DIAGNOSIS *(To be completed by physician)*

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of one of eight (8) California Veterans Homes. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for an available level of care in one or more of our facilities (SNF, ICF, RCFE, or Domiciliary). It is important that all questions be answered. (*Please attach separate pages if needed*)

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE

6. TUBERCULOSIS (TB) TEST

a. Date TB Test Given	b. Type of TB Test Given	c. Date Read	d. Test Reader Name/Title

e. Results: mm _____ f. Check if TB Test is: ☐ Negative ☐ Positive

g. Action Taken (if positive): _____

_____

h. Chest X-ray Results / Date: _____

i. Please Check One of the Following:

☐ Active TB Disease ☐ Latent TB Infection ☐ No Evidence of TB Infection or Disease

7. SERVICE CONNECTED DISABILITY DIAGNOSIS:

Service connected disability related diagnosis from page A-3 of Section A

_____ _____ _____

8. PRIMARY DIAGNOSIS:

a. Related treatment / medication (type and dosage) / equipment: _____

_____

_____

_____

b. Can patient manage own treatment / medication / equipment? ☐ Yes ☐ No

c. If no, what type of assistance or medical supervision is needed? _____

_____

_____

9. SECONDARY DIAGNOSIS(ES):

a. Related treatment / medication (type and dosage) / equipment: _____

_____

_____

b. Can patient manage own treatment / medication / equipment? ☐ Yes ☐ No

c. If no, what type of assistance or medical supervision is needed? _____

_____

_____

10. CHECK IF APPLICABLE TO 7 OR 8 ABOVE:

☐ Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.

☐ Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

11. CONTAGIOUS / INFECTIOUS DISEASE:

a. Does the resident have an active diagnosis of an infectious illness or condition? ☐ Yes ☐ No

b. If yes, what type of precautions is required to prevent transmission? _____

c. Related treatment / medication (type and dosage) / equipment: _____

_____

d. Can patient manage own treatment / medication / equipment? ☐ Yes ☐ No

e. If no, what type of assistance or medical supervision is needed? _____

_____

f. Date of last influenza vaccination _____ ☐ N/A or Unknown

g. Date of last pneumococcal vaccination _____ ☐ N/A or Unknown

12. ALLERGIES:

a. **Drugs**: List Known Drug Allergies / Reactions Below: ☐ No Known Drug Allergies

_____
_____
_____

b. **Food**: List Known Food Allergies / Reactions Below: ☐ No Known Food Allergies

_____
_____

c. Related treatment / medication (type and dosage) / equipment: _____

_____
_____

d. Can the resident manage own treatment / medication / equipment? ☐ Yes ☐ No
e. If no, what type of assistance or medical supervision is needed? _____

_____
_____

13. OTHER CONDITIONS:

a. Related treatment / medication (type and dosage) / equipment: _____

_____
_____
_____
_____
_____

b. Can patient manage own treatment / medication / equipment? ☐ Yes ☐ No

c. If no, what type of assistance or medical supervision is needed? _____

_____
_____
_____
_____

14. PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE *(If applicable)*	EXPLAIN
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Wears Prosthesis				
e. Special Diet				
f. Substance Abuse Problem				
g. Use or History of Alcohol				
h. Use or History of Cigarettes				
i. Bowel Impairment				
j. Bladder Impairment				
k. Motor Impairment / Paralysis				
l. Required Mobility Device(s)			☐ Cane ☐ Walker ☐ Wheelchair ☐ _____	
m. Requires Continuous Bed Care				
n. History / Current Skin Condition or Breakdown				

15. MENTAL CONDITION *(current diagnosis or history)*	YES	NO	EXPLAIN
a. Confused / Disoriented			
b. Inappropriate Behavior			
c. Aggressive Behavior			
d. Wandering Behavior			
e. Sundowning Behavior			
f. Able to Follow Instructions			
g. Depression			
h. Suicidal / Self-Abuse			
i. Able to Communicate Needs			
j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items			
k. Able to Safely Leave Facility Unassisted			

16. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Independently Bathe Self			
b. Able to Independently Dress / Groom Self			
c. Able to Independently Feed Self			
d. Able to Independently Care for Own Toileting Needs			
e. Able to Independently Manage Own Cash Resources			
f. Able to Independently Transfer (Chair to bed, sitting to standing, etc.)			

17. MEDICATION MANAGEMENT	YES	NO	EXPLAIN
a. Able to Independently Administer Own Prescription Medications			
b. Able to Independently Administer Own Injections			
c. Able to Independently Perform Own Glucose Testing			
d. Able to Independently Administer Own PRN Medications			
e. Able to Independently Administer Own Oxygen			
f. Able to Store Own Medications			

18. AMBULATORY STATUS:

Non-ambulatory: Means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. (Health & Safety Code Section 13131)

Bedridden: Means either requiring assistance in turning and repositioning in bed, or being unable to independently transfer to and from bed, except in facilities with appropriate and sufficient care staff, mechanical devices if necessary, and safety precautions. No resident shall be admitted or retained in a residential care facility for the elderly if the resident is bedridden, other than for a temporary illness or for recovery from surgery. (Health & Safety Code Section 1569.72)

Temporary Illness: An illness or recovery is considered temporary if it will last 14 days or less.

a. **Ambulatory Status**: This person is considered:

□ Ambulatory
□ Non-ambulatory *(complete section 17- **b** below)*
□ Bedridden *(complete sections 17- **c** and 17- **d** below)*

b. **Non-Ambulatory**: If resident is non-ambulatory, this status is based upon:

☐ Physical Condition ☐ Mental Condition ☐ Both Physical and Mental Condition

c. **Bedridden**: If a resident is bedridden, how long is bedridden status expected to persist?

1) Number of days:_____

2) Estimated date of recovery (when resident will no longer be confined to bed):_____

3) If illness or recovery is permanent, please explain: _____

_____

_____

4) If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

☐ Illness: _____

☐ Recovery from Surgery: _____

☐ Other: _____

d. **Hospice**: Is resident receiving hospice care? □ Yes □ No

If yes, specify the terminal illness: _____

19. PHYSICAL HEALTH STATUS: ☐ Good ☐ Fair ☐ Poor

20. COMMENTS: _____

_____

_____

_____

_____

21. PHYSICIAN'S NAME AND ADDRESS (PRINT)	
22. TELEPHONE	**23. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT**
24. PHYSICIAN'S SIGNATURE	**25. DATE**