ROYALE CARE, INC.

Member Application

Member Name: _____ Date of application: _____

Address: _____

Telephone number: _____ Date of Birth: _____

Primary language: _____ Gender: _____ Race/ethnicity: _____

Marital Status: Military service:

	Responsible Family Member	**Alternate Caregiver**
Name:		
Address:		
Telephone :		
Cell:		
Relationship to Member:		

Applied to be Caregiver: ☐ yes ☐ no

Name of Guardian: _____ Medical Guardian: _____ Conservator: _____

POA/DPOA/HCP ☐ yes ☐ no If yes, Name:

Primary Care Physician	Other Physician(s)	Specialty Physician(s)
Name:		
Address:		
Phone:		
Fax:		

330 SW Cutoff, Suite 102, Worcester, MA 01604 Tel: (508) 926-8848/Fax: (508) 926-8858

List Primary Medical/Psychiatric conditions/functional concerns:

_____

_____

_____

Allergies:

Review of ADL's:

Bathing: C/S A D Toileting: C/S A D Dressing: C/S A D Ambulation: C/S A D

Transfers: C/S A D Medication Mgmt: C/S A D Eating: C/S A D

Uses walker: ☐ yes ☐ no Uses Wheel chair: ☐ yes ☐ no

History of Falls: ☐ yes ☐ no Date of most recent fall: _____

Can member climb the stairs inside or outside the home? ☐ yes ☐ no

Can the member safely exit the home? ☐ yes ☐ no

Cognitive Screen: (IC observation after member interview)

_____ appears alert/ oriented _____ appears confused /disoriented

_____ appears to have short term memory loss

Behavior Screen:

_____ wanders _____ exit seeks _____ member has eloped _____ verbally abusive

_____ physically abusive _____ resists care _____ socially inappropriate/disruptive

Mental Health History:

Does member have a mental health diagnosis? ☐ yes ☐ no If yes diagnosis: _____

Does member take medication for mental health diagnosis? ☐ yes ☐ no

If yes, what:

Does member have current psychiatrist? ☐ yes ☐ no Name: _____
Phone: _____

Last Office visit: _____

Does member have current therapist? ☐ yes ☐ no Name: _____

Last Office visit: _____

Has member been Hospitalized or used crisis services : ☐ yes ☐ no

If yes, when: _____ Where: _____

Why:

Tobacco/Alcohol/Drug Use:

Does the member have a history of tobacco use? ☐ yes ☐ no Current use? ☐ yes ☐ no

If yes, how often: _____ How much: _____

Does the member have a history of consuming alcohol? ☐ yes ☐ no Current use? ☐ yes ☐ no

If yes, how often: _____ How much: _____

Does member have a history of using drugs: ☐ yes ☐ no Current use? ☐ yes ☐ no

If yes: which substance? _____

How often? _____ How much? _____

What is method of use?

Current Informal Supports:

Family /friends who assist member: ☐ yes ☐ no Who?: _____

Tasks that they assist with: _____

_____

Does member spend time outside of the home for long periods during the day? ☐ yes ☐ no

Where: _____ Overnight? _____

Do they often travel out of state or out of the country for vacation / visit family: ☐ yes ☐ no

When: With whom does he/she travel?

Current Community Services:

_____ Home Care/VNA: _____

Service provided: _____ RN _____ HHA _____ PT _____ OT _____ SLP _____ Hospice

Homecare Agency: _____

Frail Elder Waiver? Yes No

_____ PCA _____ HHA _____ Homemaker _____ Companion _____ MOW's

_____ Transportation _____ Private duty Adult Day Health: _____ How often?

Member needs/Preferences:

Do you consider yourself to be a religious or spiritual person? _____

Religious affiliation: _____ Regularly attends services: ☐ yes ☐ no

What does member like to do with free time? Hobbies, Interests? Do they have specific habits or routines that are important to them? Do they like pets? Do they have specific dietary/nutritional needs or preferences?

_____

_____

Additional Comments or notes:

_____

_____

_____

_____

Signature: Date: