Santa Teresita
A Neighborhood of Care

Dear Prospective Resident:

We thank you for choosing Santa Teresita's Good Shepherd Cottage Assisted Living as your choice of residence and care. Our Admissions Department would like to assist you in gathering all the needed documentation to complete your application process. In order to help you, here is a checklist of the items you will need to include with the submission of your application:

- ○ Complete Application
- ○ Last month's bank statement as well as prior year tax return
- ○ $750.00 refundable application processing fee
- ○ Pre-Placement Appraisal Form
  (This form is a tool to gather important information on a prospective resident. Please answer all questions included on the form to the best of your knowledge.)

- ○ Completed Physician's Report with recent TB skin test results
- ○ Current list of medications with MD signature
- ○ Copies of insurance and ID Cards:
  - Social Security Card
  - Medicare Supplemental card
  - RX/Drug Care
- ○ Durable Power of Attorney for Healthcare
- ○ Power of Attorney for Finances

Should you have any questions or concerns during the application process, we are available to assist you; Please do not hesitate to contact us.

Santa Teresita Admissions Department
Cell 626.734-2102 / Fax 626.256-1931

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Good Shepherd Assisted Living Cottage
RCFE License # 198602600
1218 Royal Oaks Dr / Monrovia, CA 91016

On the Santa Teresita Campus
819 Buena Vista Street / Duarte, CA 91010

Residential Application

Applicant Name:

Last Name	First Name	Marital Status
Address	City/State	Zip Code
Telephone #	Place of Birth	Date of Birth
Social Security #	Medicare #	Medi-cal #
Name of Secondary Insurance	Group #	I.D. #
Name of HMO	Group #	I.D. #

Medical Power of Attorney Agent:

Name	Telephone #
Address	
Email Address	

Financial Power of Attorney Agent: (Financial Form must accompany application.)

Name	Telephone #
Address	
Email Address	

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Primary Care Physician:

_____

Name Telephone #

_____

Address

Executor of Estate:

_____

Name Telephone #

Mortuary:

_____

Name Telephone #

Pre-admission Living Arrangement:

- ☐ Private Home / Apt Alone
- ☐ Private Home / Apt with other
- ☐ Another Assisted Living
- ☐ Skilled Nursing
- ☐ Other

*If coming from another facility, please provide name: _____

Former Occupation: _____

Church Affiliation / Religious Preference: _____

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Residential Application – Statement of Financial Condition

Applicant Name (Please Print):

_____

Last Name First Name Date

Monthly Income

Social Security_____ Amount _____

Pensions (Source) _____ Amount _____

Annuities _____ Amount _____

Rental Income _____ Amount _____

Assets

Cash _____ Amount _____

Checking _____ Amount _____
Banking Institution: _____Account #_____Description: _____
Savings_____ Amount _____

Banking Institution: _____Account #_____Description: _____
Investment Portfolio _____ Amount _____

Banking Institution: _____Account #_____Description: _____

Life Insurance (whole life) _____ Amount _____

Stocks and Bonds: _____ Amount _____
Description: _____

Burial Insurance: _____ Amount _____

Burial Plot: _____Amount _____

Properties:

Type _____ Amount _____
Other _____ Amount _____

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Liabilities

Loans/Mortgages _____ Amount _____

Credit Cards _____ Amount _____

Judgment Creditors _____ Amount _____

A copy of last year's tax return and most recent bank statement must be submitted with this application.

Signature of Resident / Responsible Party: _____

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Assisted Living Residential Criteria Acknowledgement
(References: from Title 22 87459, 87455, 87465, 87611-87631)

1) Resident should be at least 60 years of age, and able to adapt to community.
2) Residents may only be accepted who require incidental medical services including, but not limited to those specific situations specified in Title 22, Division 6, Chapter 8, Sections 87611 through 87631, of the Manual of Policies and Procedures for Residential Care Facilities for the Elderly:
    a. Residents with the following conditions or care requirements may be admitted provided care is administered in accordance with attending physicians orders and the Resident can determine need for service and do self-care or care is provided by an appropriately trained skilled nursing professional approved by the Department of Social Services: oxygen, IPPB machine, colostomy or ileostomy, and indwelling urinary catheter, incontinence, diabetes, or injections.
    b. Healing wounds where care is performed by or under the supervision of a skilled medical professional and is approved by the Department of Social Services.
    c. Hospice care if license has a waiver and the RCFE administrator approves.
3) The following health conditions are prohibited in residential care:
    a. Gastrostomy care, liquid oxygen, naso-gastric tubes, serious infections.
    b. Residents who depend on others to perform all activities of daily living as set forth in Section 87584.
4) Resident agrees to design a Service Plan with staff, which is to be reviewed by-annually or as needed.
5) Resident agrees to abide by agreed upon services.
6) Resident is able to transfer from bed to chair independently.
7) Resident is able to self-manage bowel care.
8) Resident is able to transport self to dining room with or without mechanical aide.
9) Resident is able to feed self without assistance.
10) Resident has safety awareness.
11) Resident can follow directions to evacuate building.
12) Resident has the mental acuity to communicate to staff and to operate the emergency call device.
13) Resident has not indicated a propensity to wander.
14) Resident agrees to relocation if the established criteria can no longer be met, and/or the residential level of care cannot meet the needs of the Resident. If Resident cannot pay for additional needed services and qualifies for Medi-Cal Long Term Care, Resident agrees to transfer to skilled nursing.
15) Family may assist Resident financially to pay for any residential costs.

By signing below, I am acknowledging that I have been informed about the criteria for admission to Cristo Rey or Good Shepherd Assisted Living Cottages according to California State Regulations in Title 22. I understand that eligibility for residency is determined according to these regulations and facility policy. If at anytime I am no longer eligible to reside in Assisted living, I will be assisted to find other residence.

Signature of Resident and/or Responsible Party:
Signature: _____ Date: _____

Revised March 2020

Pre-Placement Appraisal

NOTE: This information may be obtained from the applicant, or his/her authorized representative. (Relatives, Social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).

APPLICANT'S NAME: _____ AGE: _____

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e. active or withdrawn))

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS:

- ☐ Out of bed all day
- ☐ In bed most of the time
- ☐ In bed part of the time

Comments on bed status:

TUBERCULOSIS INFORMATION:
ANY HISTORY OF TURBECULOSIS IN APPLICANT'S FAMILY? ☐ YES ☐ NO
DATE OF TB TEST: _____ ☐ POSITIVE ☐ NEGATIVE

ACTION TAKEN (IF RESULTS WERE POSITIVE):

ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS? ☐ YES ☐ NO
GIVE DETAILS:

AMBULATORY STATUS (This person is ☐ ambulatory ☐ non-ambulatory)
Ambulatory means able to demonstrate the mental and physical ability to leave a building without assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

YES	NO	
		Able to walk without any physical assistance (walker, crutches, other person), or able to walk with a cane.
		Mentally and physically able to follow signals and instructions for evacuation.
		Able to use evacuation routes including stairs if necessary.
		Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below

YES	NO	
		Active, requires no personal help of any kind – able to go up and down stairs easily
		Active, but has difficulty climbing or descending stairs
		Uses brace or crutch
		Feeble or slow
		Uses walker. If yes, can get in and out unassisted?
		Uses wheelchair. If yes, can get in and out unassisted?
		Requires grab bars in bathroom
		Other: (Describe)

SERVICES NEEDED (Check items and explain)

YES	NO	
		Help in transferring in and out of bed and dressing _____
		Help with bathing, hair care, personal hygiene _____
		Does client desire and is client capable of doing own personal laundry and other household tasks? _____
		Help with mobbing about the facility _____
		Help with eating (need for adaptive devices or assistance from another person.) _____
		Special diet/observation of food intake _____

		Toileting, including assistance equipment, or assistance of another person _____
		Continence, bowel or bladder control. Are assistive devices such as a catheter required? _____
		Help with medication _____
		Needs special observation/night supervision (due to confusion, forgetfulness, wandering) _____
		Help in managing own cash resources _____
		Help in participating in activity programs _____
		Special medical attention_____
		Assistance in incidental health and medical care _____
		Other "services needed" not identified above _____

Is there any additional information which would assist the facility in determining applicant's suitability for admission? (If yes, please attach comments on separate sheet).
☐ YES ☐ NO

To the best of my knowledge, I (or the above person) do not need skilled nursing care.
SIGNATURE (Person Completing Form): _____
DATE COMPLETED _____

APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE SIGNATURE: _____
DATE COMPLETED: _____

LICENSEE OR DESIGNATED REPRESENTATIVE: _____
DATE COMPLETED: _____