

TITLE XIX
MEDICAL/SOCIAL INFORMATION FORM

PART I - IDENTIFYING AND SOCIAL INFORMATION

Name:			Medicaid ID Number:		
Home Address:			Medicare Eligible:		
			SS#:		
City	State	Zip	Birth Date:		Sex:
Number of Children:			Highest Grade Completed:		
Marital Status:			Kinds of Jobs Held:		
Responsible Relative/Curator:				Relationship:	
Address:					

SPOUSE/FAMILY/FRIENDS WHO MAINTAIN CONTACT AND/OR PROVIDE CARE

Name	Relationship	Address	Telephone

LIVING ARRANGEMENTS PRIOR TO ADMISSION TO A RESIDENTIAL FACILITY

Own Home	Relative Home	Boarding Home	Other
Lived With: Spouse	Children	Alone	Home: House Apartment

PREVIOUS INSTITUTIONAL CARE (INCLUDING NURSING HOMES)

Name:	Dates:
Name:	Dates:

HOME OR COMMUNITY SERVICES CONSIDERED OR USED

Adult Care	Homemaker	Habilitation Services	Home Health Care
Meals on Wheels or Congregate Meals		Other	
Why are (were) Services Not Suitable			

MY CHOICE OF SERVICE IS

1. Nursing Home Care ()	Name of Facility if Known:	
	Address:	
2. Community or Homebased Care ()	Type:	
Will you need this service:	Temporarily	Permanently
Why do you need services at this time:		

FAMILY MEMBER OR PERSON WHO WILL ASSIST IN DISCHARGE PLANNING FOR THIS PATIENT

Name:	Telephone Number:
Address:	Relationship to Patient:
Signature of Applicant or Responsible Relative or Curator	
Date	

PART II - MEDICAL INFORMATION

The information below except for physical examination and level of care recommendation may be completed by physician, or by facility and approved by physician.

Mental Status and Behavior (Check YES or No: If YES, Circle: 1-Seldom 2-Frequent 3-Always)	
Oriented (YES ___ 1 2 3) (NO ___)	Confused (YES ___ 1 2 3) (NO ___)
Forgetful (YES ___ 1 2 3) (NO ___)	Wanders (YES ___ 1 2 3) (NO ___)
Depressed (YES ___ 1 2 3) (NO ___)	Hostile (YES ___ 1 2 3) (NO ___)
Comatose (YES ___ 1 2 3) (NO ___)	Combative (YES ___ 1 2 3) (NO ___)

Communication (Check YES or NO) PLEASE COMMENT ON FUNCTIONAL LEVEL OF PATIENT

Verbal (YES ___ NO ___)	Wears Glasses (YES ___ NO ___)
Non-Verbal (YES ___ NO ___)	Deaf (YES ___ NO ___)
Blind (YES ___ NO ___)	Hearing Aid (YES ___ NO ___)

ACTIVITIES OF DAILY LIVING

	Self	Minimal Assist	Maximum Assist	Ambulation		Appetite	
Eating	()	()	()	By Self	()	Good	()
Bathing	()	()	()	With Walker	()	Fair	()
Personal Grooming	()	()	()	With Assistance	()	Poor	()
Oral Hygiene	()	()	()	Uses Cane	()	Dentures	()
Dressing	()	()	()	Mobile per Wheelchair	()	Tube Feed	()
				Chair Bound	()		
				Bed Bound	()		

