**Clare Housing Care Home Application Part B.** This part of the application must be filled out by applicant’s infection disease or primary provider.

**PLEASE EMAIL COMPLETED Applications to: HousingApplicant@clarehousing.org**

**OR FAX TO:612 236 9520**

Date of Application**:** \_\_\_\_\_\_\_\_\_\_\_\_Applicant name: \_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Fax :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant Basic Health Profile:**

Allergies (please provide rxn if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any major weight losses or gains in the last year, if yes explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide copy of immunization record.**

Date of last hospitalization and reason:

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

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

**HIV Health:**

Date of HIV infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of AIDS diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current viral load (please provide date): \_\_\_\_\_\_\_\_\_\_ Current CD4 count:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Health and/or Treatments:**

Does the applicant use adaptive equipment, if so, please list (walker, wheelchair etc.)

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

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

Does the applicant have: [ ] Dentures [ ] Corrective lens [ ] Hearing Aid

Does the applicant have any existing ports or catheters? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is the applicant receiving any of the following treatments or therapies:**

[ ] Dialysis

[ ] Tube Feeding

[ ] Supplemental Oxygen

[ ] CPAP

[ ] BIPAP

[ ] Cough Assist

[ ] Ostomy care

[ ] Catheter care

[ ] Wound care

[ ] Physical Therapy

[ ] Occupation Therapy

[ ] Speech Therapy

[ ] IV Fluids

[ ] IV medication

[ ] IV site care

[ ] Blood Transfusions

1. **APPLICANT’S MEDICAL HISTORY**

**Please provide a list of diagnoses with ICD 10 codes**

Any recent health issues

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

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Does the applicant have a history of **mental health issues** ? If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the applicant last **use substances** (meth, crack, marijuana, heroin, opioids etc)? If so, what substances, please describe:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Systems overview**

**CARDIOVASCULAR**

[ ]  No Problems

[ ]  Chest Pain

[ ]  Palpitations

[ ]  Edema

[ ]  SOB

[ ]  Hypertension

[ ]  Pacemaker

[ ]  Anemia

**RESPIRATORY**  [ ] No Problems

[ ]  Shortness of Breath with:

 \_\_\_\_rest \_\_\_\_Activity

[ ] Wheezing

[ ] Cough - TYPE:

 \_\_\_\_Dry \_\_\_\_Productive

[ ]  Smoker

[ ]  Asthma

**URINARY**

[ ]  No Problems

[ ]  Hesitancy when urinating

[ ]  Frequency urination

[ ]  Bladder infections

[ ]  Dribbling of urine

[ ]  Urine incontinence

**ENDOCRINE**  [ ] No Problems

[ ] Excessive thirst

[ ] Excessive hunger

[ ] Heat or Cold Intolerance

[ ] Thyroid

[ ] Diabetes

[ ] Other

**COMMENTS:**

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

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

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

**COMMENTS:**

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

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

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

**COMMENTS:**

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

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

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

**COMMENTS:**

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

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

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

**NEUROLOGICAL**

[ ] No Problems

[ ]  Balance

[ ]  Fainting/dizziness

[ ]  Seizures

[ ]  Tremors

[ ]  Falls

[ ]  Gait imbalances

[ ]  CVAs

[ ]  Paralysis

[ ]  Other

**GASTROINTESTINAL**

[ ]  No Problems

[ ]  Difficulty swallowing

**COMMENTS:**

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

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

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

**COMMENTS:** Click or tap here to enter text.

[ ]  Bowel incontinence

[ ]  Other

[ ]  Belching

[ ]  Abdominal pain

[ ]  Hemorrhoids

[ ]  N/V

[ ]  Ulcers

[ ]  Constipation

[ ]  Heart burn

**MUSCULOSKELETAL COMMENTS:** Click or tap here to enter text.

[ ]  No Problems

[ ]  Stiffness

[ ]  Weakness

[ ]  Cramps

[ ]  Back Pain

[ ]  Joint Problems

[ ]  Amputation

[ ]  Other

**SKIN COMMENTS:** Click or tap here to enter text.

[ ]  No Problems

[ ]  Rashes

[ ]  Statis ulcers

[ ]  Dryness

[ ]  Itching

[ ]  Decubitus ulcer

[ ]  Other

**What other providers, treatment or counseling is applicant receiving?**

[ ]  Psychiatry

[ ]  Psychotherapy

[ ]  Addiction medicine/chemical health counseling

[ ]  Neurology

[ ]  Endocrinology

[ ]  Dermatology

[ ]  Opthamology

[ ]  Cardiology

[ ]  Pulmonology

[ ]  Orthopedics

[ ]  Physical therapy

[ ]  Urology

[ ]  Gynecology

[ ]  Oncology

[ ]  Gastroenterology

[ ]  Nephrology

[ ]  Podiatry

[ ]  Other:

Does the applicant keep scheduled appointments? [ ]  Yes [ ] No

In your opinion, is the applicant functionally impaired? [ ]  Yes [ ] No

Functionally impaired means a person who has:

* Substantial difficulty carrying out one or more of the essential major activities of daily living, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working; or
* A disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

Do you have any concerns about the applicant’s ability to drive a car safely? □ Yes □No

Will you continue to provide medical care to the applicant if the applicant moves into the care homes?

**Clare Care Homes operates under 245D license which does not require nursing oversight, if this applicant becomes a resident of adult foster care, does the staff after training from you or by registered agency (such as Health Counseling Services) have your permission to administer medications?**

[ ]  Yes [ ] No [ ]  Yes, with exceptions (If SQ injections are on medication list then a separate injection form must be signed for ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional comments that would assist in planning care for this applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On the basis of my examination, it is my finding that the above-named applicant does not have any condition communicable disease or otherwise that might endanger foster care home residents.

Providers Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_