**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:

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

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**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.)

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

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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:**

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

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**COMMENTS:**

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**COMMENTS:**

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**COMMENTS:**

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**NEUROLOGICAL**

No Problems

Balance

Fainting/dizziness

Seizures

Tremors

Falls

Gait imbalances

CVAs

Paralysis

Other

**GASTROINTESTINAL**

No Problems

Difficulty swallowing

**COMMENTS:**

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

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**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_