Top Aid Healthcare, INC

Member Application

Member name _____ Date _____

Address _____

Telephone Number _____ DOB _____

Primary Language _____ Gender _____ Race/ethnicity _____

Marital Status _____ Military service _____

Responsible Family Member	Alternate Caregiver
Name _____	_____
Address _____	_____
_____	_____
Phone Number _____	_____
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 Physicians	Other Physician	Special Physician
Name _____	_____	_____
Address _____	_____	_____
_____	_____	_____
Phone _____	_____	_____
Fax _____	_____	_____

List Primary Medical/Psychiatry conditions/functional concerns:

_____

_____

Allergies _____

Review of ADL's

Bathing C/S AD Toileting C/S AD Dressing C/S AD Ambulation C/S AD

Transfer C/S AD Medication Mgmt.: C/S AD Eating C/S AD

Uses walker Yes____ NO____ Uses wheelchair YES____ No____

History of falls YES____ NO____ Date of most recent falls _____

Can Member climb the stairs inside or outside the home? Yes_____ NO_____

Can The Member Safely exit the home? Yes____ NO____

Cognitive Screen (observation after member interview)

_____appears alert/ orientated _____appears confused/ disorientated.

_____appears to have short term memory loss.

Behavioral Screen:

____ wonders ____ exits seeks ____ member has eloped ____ verbal abusive.

____physically abusive ____ resist 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 Name of medications

_____

_____

Does Member have a Current Psychiatry? _____ YES NO _____

IF Yes name of Psyc _____

Address _____

Phone Number _____

Last office visit _____

Does Member have a therapist? _____ YES NO _____

If Yes Therapist Name _____

Address _____

Phone Number _____

Last office Visit _____

Has Member been hospitalized or used crisis services? _____ YES No _____

IF yes Where _____

Address _____

Phone Number _____

Person to Contact _____

Why?

_____

_____

_____

Tobacco/Alcohol/Drug use

Does Member Have a history of Tobacco use? ____ YES No____ Current user? ___YES No ___

If yes how often? _____ How much? _____

Does Member have a history of consuming alcohol? ____ YES NO ___ Current user? __YES NO ___

IF yes How often? _____ How much? _____

Does Member Have a history of drug use? ___ YES NO ____ Current user? ____ YES NO ____

If yes Itch Substance? _____

How often? _____ How Much? _____

What is the method of use? _____

Current Informal Supports

Family/friends who assist member ____ YES NO _____ Who? _____

Task they assist with

_____

_____

_____

Does Member spend time outside of the home for a long period during the day? ___ YES NO _____

If yes Where _____

_____

Any overnights? ___ YES NO ___

If yes where? _____

_____

Do they often travel out of state or out of country for Vacation? _____ YES NO _____

IF yes where? _____

with whom does the client travel with? _____

Current Community Services

_____ Home Care/VNA _____

Service provider _____ RN _____ HHA _____ PT _____ OT _____ SLP _____ Hospice

Home Care Agency _____

Frail elder Waiver? _____ Yes NO ____

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

_____ Transportation _____ Private Duty _____ Adult day health

How Often? _____

Members need preference.

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

Religious Affiliation _____ Regularly attends services ____ YES NO ____

What does the Member like to do with his/her free time? (Hobbies Interest? 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

Signature _____ Date: _____