Jennings

10204 Granger Road
Garfield Heights, OH 44125

www.jenningsohio.org
216-581-2900

Jennings Assisted Living

Jennings Assisted Living is ideal for individuals who seek an independent or supported lifestyle in a community with the convenience of amenities and services.

Jennings offers choices in distinctive supportive residences on our Garfield Heights campus. Bringing together the traditions of neighborhood and home, Jennings offers you the opportunity to enjoy the everyday elements of community life while providing the extra support you may need.

From lifestyle choices to health and personal care, our staff provides a wide range of support to ensure your comfort and well-being. The varying service levels help you to live comfortably now as well as plan for any temporary or changing needs.

With 80 years of experience, Jennings offers choices for individuals to live independently while accessing amenities and services. We respect each individual's unique preferences so you can enjoy the lifestyle you expect. Comfortable private suites need only your personal touch with your furniture and home furnishings. Social areas, activities and amenities invite friendships and enable the spirit of community to flourish.

Celebration of Life

A balance of privacy and social activity enables residents to make your own individualized choices. Celebrations, life-enriching recreational programs, amenities and lifelong learning activities provide the channel for virtually all interests. Each resident's choices are important and we honor them.

Jennings offers two unique residences for your lifestyle choices.

Traditional Assisted Living: Catered Living

A traditional assisted living environment offers a comfortable catered lifestyle. Residents enjoy independence in apartment-style suites with opportunities to enjoy plentiful amenities, in addition to socializing, outings and daily life.

From catered independence to all-inclusive services, Jennings provides a number of lifestyle options. Our culinary services team serves home-cooked meals restaurant style. Comfort is knowing that our service plans provide a full variety of support, to serve you now or for any future needs. Our dedication to quality care, which we uphold through our mission and values, is demonstrated by our commitment to supporting your needs and choices.

Holy Spirit Ridge: A Small Living Natural Home Environment

Holy Spirit Ridge offers a natural home environment for residents. The house philosophy is that of a nationally recognized "small house" - residents direct the daily life and live family style.

The philosophy of care is that of a nationally recognized "small house" approach. Individuals in the house enjoy practices designed to make each day meaningful, and we make connections in ways from one-on-one interactions to conversations over a family style meal at the table. Residents participate in the life and decisions of the house, such as meal preferences and recipes, thereby deeply honoring their lifelong daily rhythms.

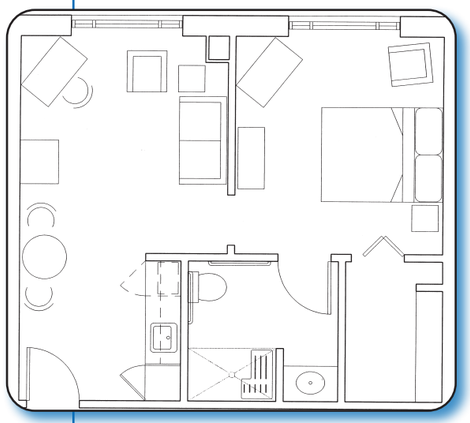
Traditional Assisted Living

Key Features

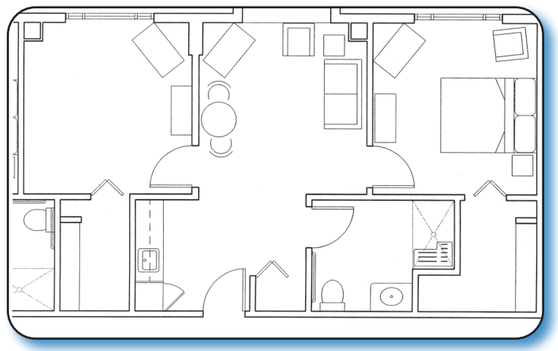
- Choice of 54 spacious apartment-style suite floor plans: studio, one-bedroom or two-bedroom
- Suite features kitchenette with refrigerator/freezer, microwave, sink, pantry and cabinets
- Three homestyle meals each day, served restaurant style
- Cable TV and wi-fi included
- Secured key card entrance from outside; key-lock suite entry
- Includes electricity, gas heat, air conditioning and water. Connection for private telephone and Internet in suite (resident must choose and authorize service)
- Private mailbox
- Emergency call system
- Individual thermostat for heating and air conditioning

Amenities

- Open pantry with snacks available 24 hours each day
- Reserved parking space near building (includes snow removal)
- Free laundry facilities on each floor
- Trash chute on each floor
- Daily activities, as well as special events and regular group trips
- Beauty/barber services
- Banking services
- Spiritual programs and on-site Chapel
- Wellness services on-site
- Fitness equipment and exercise programs
- 24-hour nursing staff support
- Outdoor patio and gardens
- Community rooms for private family gatherings



One Bedroom Suite (475 sq. ft.)



Two Bedroom Suite (615 sq. ft.)

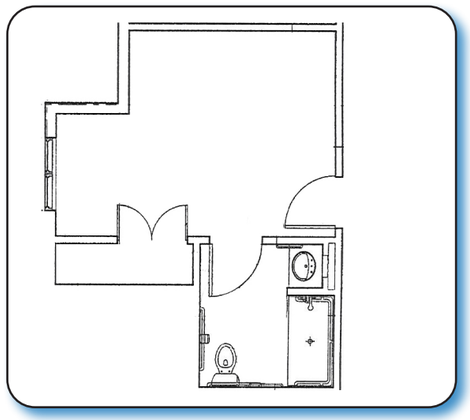
Holy Spirit Ridge

Key Features

- Natural home design for 19 residents in the house
- All private studios with open floor plan and private bathroom with shower
- Resident-defined choices for three home-cooked meals each day, served family style
- Person-centered care approaches
- Mail delivered to suite
- Small domestic pet welcome
- Includes all utilities: cable TV, electricity, gas heat, air conditioning and water, private telephone and wifi
- Secured key card entrance from outside; key-lock suite entry
- Emergency call system
- Freedom of space with indoor and outdoor areas for residents to enjoy

Amenities

- Open kitchen with pantry available 24 hours each day and opportunities for cooking or baking
- Reserved parking space near building (includes snow removal)
- Free laundry facility
- Trash removal each day
- Daily activities, as well as special events and regular group trips
- Beauty/barber services
- Banking services
- Spiritual programs and on-site Chapel
- Fitness equipment and exercise programs
- 24-hour nursing staff support
- Outdoor patio and gardens
- Community rooms for private family gatherings



Studio Suite
(approximately 290 sq. ft.)

Jennings

Lifelong learning and activities to discover potential

Physical fitness and access to therapies and wellness services

Intergenerational programs

Quality, relationship-based care

Concerts and performances

Special events

About Jennings

For 80 years, Jennings has nurtured the body, mind and spirit of adults over 55. Jennings is a local, vibrant, non-profit organization, rooted in its Catholic foundation and serving people of all faiths. As a continuum of care, Jennings offers a residences and services through a continuum of care in Northeast Ohio.

Our Mission

Rooted in Catholic values, Jennings celebrates and nurtures individuals as they age, through exceptional choices and continuous innovation.

We commit ourselves to our mission through:
Respect | Compassion | Community
Discovery of Potential | Celebration of Life

Brecksville
Chardon
Garfield Heights
Shaker Heights

www.jenningsohio.org

216-581-2900

Information subject to change without notice.

PUB135542FS_12302023

Traditional Assisted Living

Service Highlights

	Basic Services	Support Services	Medication Services	Enhanced Services	All-inclusive Services
Culinary Services					
• Three (3) meals per day served restaurant style	✓	✓	✓	✓	✓
• Specialized dietary considerations	✓	✓	✓	✓	✓
• Snacks and meals available 24 hours/day	✓	✓	✓	✓	✓
Housekeeping					
• Full house cleaning frequency	every other week	once per week	every other week	once per week	as needed
• Bed making and linen changes		weekly		daily	bed daily/linens weekly
• Trash removal	daily	daily	daily	daily	daily
• Laundry		weekly		weekly	as needed
Health and Wellness Services					
• Check of vital signs/weight	monthly	monthly	as needed	as needed	as needed
• Scheduling and arranging medical tests, liaison with family and physician				✓	✓
Medication Administration					
• Administering and coordinating medications			✓	✓	✓
• Blood glucose monitoring			✓	✓	✓
Memory Support					
• Cueing, reminders, support					✓
Personal Care Services					
• Assistance with compression stockings, shoes, socks		✓		✓	✓
• Bathing assistance		2x per week		3x per week	as needed
• Reminders for meals		✓		✓	✓
• Checking on resident at family's request		✓		✓	✓
Social Services					
• Case management and service coordination	✓	✓	✓	✓	✓
• Pastoral care services	✓	✓	✓	✓	✓

Assisted Living Monthly Rates

Effective January 1, 2023

Application Fee	No charge
Assessment Fee	No charge
Security Deposit (See Section II C of Residency Agreement)	$1000.00

Assisted Living

Studio (based on 30 days)

	One Person
Basic Service Plan	$ 2,700/month
Support Service Plan	$ 3,360/month
Medication Service Plan	$ 3,780/month
Enhanced Service Plan	$ 4,470/month
All-Inclusive Service Plan	$ 5,160/month

1 bedroom/1 bath suite (based on 30 days)

	One Person	**Two People**
Basic Service Plan	$ 3,600/month	$ 5,190 /month
Support Service Plan	$ 4,470/month	$ 6,090 /month
Medication Service Plan	$ 5,040/month	$ 6,690 /month
Enhanced Service Plan	$ 5,940/month	$ 7,620 /month
All-Inclusive Service Plan	$ 6,870/month	$ 8,580 /month

2 bedroom/1.5 bath suite (one or two persons)

Basic Service Plan	$ 6,840/month
Support Service Plan	$ 7,440 /month
Medication Service Plan	$ 8,130 /month
Enhanced Service Plan	$ 8,940 /month
All-Inclusive Service Plan	$ 9,570 /month

Holy Spirit Ridge

Service Highlights

	Basic Services	Support Services	Complete Services
Culinary Services			
• Three (3) meals per day served family style	✓	✓	✓
• Specialized dietary considerations	✓	✓	✓
• Snacks and meals available 24 hours/day	✓	✓	✓
Housekeeping			
• Full house cleaning frequency	every other week	once per week	once per week
• Bed making and linen changes		weekly	daily
• Trash removal	daily	daily	daily
• Laundry		weekly	up to four (4) loads per week
Health and Wellness Services			
• Clinical assessment and support			as needed
• Coordinating and assisting with medications, including cueing a resident in taking their medications, opening the packages, pouring medications in to resident hand or medication cup and and watching the resident consume the medications		coordination of medication ordering, and packaging only	full coordination and assistance
Personal Care Services			
• Assistance with compression stockings		✓	✓
• Bathing assistance		2x weekly	2x weekly
• Reminders for meals		✓	✓
• Checking on resident at family's request		✓	✓
• Assisting with activities of daily living (such as transitioning and rest room needs)			✓
Social Services			
• Case management and service coordination	✓	✓	✓
• Pastoral care services	✓	✓	✓

Holy Spirit Ridge
Monthly Rates
Effective January 1, 2023

Application Fee	No charge
Assessment Fee	No charge
Security Deposit (See Section II C of Residency Agreement)	$1000.00

Assisted Living

Studio (based on 30 days)

	One Person
Basic Service Plan	$ 2,700/month
Support Service Plan	$ 3,330/month
Complete Service Plan	$ 4,770/month

1 bedroom/1 bath suite (based on 30 days)

	One Person
Basic Service Plan	$ 3,600/month
Support Service Plan	$ 4,470/month
Complete Service Plan	$ 5,940/month

Thank you for your interest in Jennings. Attached you will find an application to apply for an assisted living or long-term care residence at Jennings. Please complete this application, sign, and return it to us. The addresses for our Garfield Heights and Brecksville residences are listed below. Jennings does not discriminate against applicants or residents in the provision of services or in any other manner on the grounds of race, color, creed, religion, sex or national origin. **Please note that Jennings is a non-smoking campus.**

INSTRUCTIONS

The information requested in this application is required to help determine that your ability to pay for the services you are requesting. Please answer each question truthfully and completely. Incomplete or inaccurate answers to questions may delay the processing of the application, and untruthful answers may result in a denial of the application.

The application will proceed when this form (along with supporting documentation) has been completed, signed, and returned to Jennings. Please send the completed application to:

GARFIELD HEIGHTS:
Jennings
10204 Granger Road
Garfield Heights, OH 44125
ATTN: Admissions

OR

BRECKSVILLE:
Jennings at Brecksville
8736 Brecksville Road
Brecksville, OH 44141
ATTN: Admissions

The information provided will be reviewed by Jennings and is subject to independent verification by third parties. Jennings will take reasonable steps to ensure the confidentiality of the information provided; however, we cannot guarantee that the information will be kept confidential.

If a decision is made for you to become a resident of Jennings, then you will need to sign various documents, including an admission agreement. In addition, Jennings requires that another person besides the resident also sign the admission agreement. This other person is referred to as the “Representative.” The Representative will act on the resident’s behalf to satisfy his/her financial obligations under the admission agreement if the resident chooses not to, or is unable to, meet those obligations. Thus, the Representative has legal access to the resident’s income, assets or resources, including, but not limited to, social security, pension or retirement funds, annuities, insurance, bank accounts, and mutual funds.

If you have any questions or concerns, please contact us at (216) 581-2900.

Jennings

Brecksville: 8736 Brecksville Road; Brecksville, OH 44141
Garfield Heights: 10204 Granger Road, Garfield Heights, Ohio 44125
Phone: (216) 581-2900 | Fax: (216) 472-2693 | Web: jenningsohio.org

Application for Residence

Today's Date: _____ Requested Date of Residence: _____

Interest (check all that apply) ____ Assisted Living Garfield Heights ____ Holy Spirit Ridge Garfield Heights ____ Assisted Living Jennings at Brecksville ____ Long-term Care ____ Respite

APPLICANT(S) INFORMATION

APPLICANT 1

Full Name

Address

Address line 2

City State Zip

Phone

Email

Sex Birthdate Age

Single Married Divorced Separated Widowed

Marital Status (circle one)

Religious Preference Parish

Are you a U.S. Citizen? □ Yes □ No

Are you a veteran? □ Yes □ No
If yes, please list branch of service: _____

Physician

Physician phone number

Health System

APPLICANT 2 (If applicable)

Full Name

Address

Address line 2

City State Zip

Phone

Email

Sex Birthdate Age

Single Married Divorced Separated Widowed

Marital Status (circle one)

Religious Preference Parish

Are you a U.S. Citizen? □ Yes □ No

Are you a veteran? □ Yes □ No
If yes, please list branch of service: _____

Physician

Physician phone number

Health System

Applicant Information

Please complete the following information. If any question does not apply, please mark "N/A"

		Applicant #1	Applicant #2
Social Security Number		_____	_____
Medicare Number		_____	_____
Private Insurance	Insurer Name	_____	_____
	Policy number	_____	_____
	Member ID#	_____	_____
Have you ever applied for Medicaid?		□ Yes □ No	□ Yes □ No
	If Yes, When?	_____	_____
	State and County	_____	_____
Please list any additional services from other sources (i.e., PASSPORT)		_____	_____

Health Information

Applicant #1

Last hospital stay approximate date(s):_____

Hospital: _____

Describe surgical history:

Describe any health conditions or challenges:

Any confusion, memory loss or wandering at night?

Applicant #2

Last hospital stay approximate date(s):_____

Hospital:_____

Describe surgical history:

Describe any health conditions or challenges:

Any confusion, memory loss or wandering at night?

Advance Directives

Have you prepared and signed any of the following advance directives?

	Applicant #1	Applicant #2
Financial Power of Attorney	□ Yes □ No	□ Yes □ No
Print Name of first FPOA	_____	_____
Print Name of second FPOA	_____	_____
Durable Power of Attorney for Health Care	□ Yes □ No	□ Yes □ No
Print Name of first HPOA	_____	_____
Print Name of second HPOA	_____	_____
Living Will	□ Yes □ No	□ Yes □ No
Provision for Do Not Resuscitate (DNR) order	□ Yes □ No	□ Yes □ No
Do you have a court appointed guardian:?	□ Yes □ No	□ Yes □ No
Print Guardian Name	_____	_____

Upon lease signing, please include copies of any documents that support your answers.

Financial Information

Monthly Income.
For each income source below, indicate the monthly amount and in whose name the account is listed.
Please provide copies of supporting documents.

Social Security	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Veterans Benefits	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Pension and/or Annuities	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Dividends and Interest	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Other _____	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____
Other _____	Applicant 1 $ _____	Applicant 2 $ _____	Joint $_____

Current Monthly Expenses.
For each expense below, indicate the monthly amount.

Home Mortgage/Rent (circle one)	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Home Maintenance Fee	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Credit Cards/Charges	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Loans	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Prescription Expenses	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Health Insurance Premium	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Household Expenses	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____
Homeowner's Insurance	Applicant 1 $_____	Applicant 2 $ _____	Joint $_____

Other (for example student loans, child support, etc.)

specify $_____ ❑Applicant 1 ❑Applicant 2 ❑Joint

specify $_____ ❑Applicant 1 ❑Applicant 2 ❑Joint

Real Estate Taxes $ _____ ❑Per Year ❑Per Half-year

Asset Transfers and Trusts

Have you transferred any assets (i.e., gifts, real estate, bank accounts, money, cars, houses, jewelry, bonds, stocks, etc.) to anyone in the last five (5) years? ❑**No** ❑**Yes**
If yes, please provide the name of the person to whom you made the transfer, what was transferred, the amount/value of what was transferred and when the transfer was made (attach any additional pages if necessary):

Name	Asset Transferred	Amount/Value	Date of Transfer

Have you created any trusts in the last five (5) years? ❑No ❑Yes If yes, please provide the name of the trustee, type of trust, amount/value of the trust and the date the trust was created (attach any additional pages if necessary):

Name	Asset Transferred	Amount/Value	Date of Transfer

Financial Information

Type	Account Holder	Financial Institution	Value/Amount	Name(s) on Account in addition to Applicant	Is account held in trust?
Savings	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Savings	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Checking	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Checking	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Certificate	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Certificate	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Stock	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Bond	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Mutual Fund	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Life Insurance	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Real Estate	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Other	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No
Other	❑Applicant 1 ❑Applicant 2 ❑Joint				❑Yes ❑No

Financial Responsibility

Applicant and/or Financial Power of Attorney please sign below:

I hereby affirm that, to the best of my knowledge, the information provided is true. I understand that Jennings will rely upon the accuracy and completeness of the above financial information in making a decision. Applicant and/or Financial Power of Attorney shall be responsible for insuring the cost of care from the applicant's funds. I/We will provide copies of legal documents (such as Financial or Durable Power of Attorney or Guardianship) upon admission.

Applicant (print name) _____ Signature _____ Date _____

Applicant 2 (print name) _____ Signature _____ Date _____

Representative _____ Signature _____ Date _____

Representative Social Security Number: _____

Required for those who have access to the applicant(s) funds.

Family Information: Contact in Case of Emergency

Name ______________________ Relationship ______________ Phone: ______________
Address ______________________ Cell: ______________
Email ______________________ Other: ______________

Check all that apply: □ Responsible Party: Financial □ Responsible Party: Health Care □ Emergency Contact 1 □ Emergency Contact

Name ______________________ Relationship ______________ Phone: ______________
Address ______________________ Cell: ______________
Email ______________________ Other: ______________

Check all that apply: □ Responsible Party: Financial □ Responsible Party: Health Care □ Emergency Contact 1 □ Emergency Contact

Name ______________________ Relationship ______________ Phone: ______________
Address ______________________ Cell: ______________
Email ______________________ Other: ______________

Check all that apply: □ Responsible Party: Financial □ Responsible Party: Health Care □ Emergency Contact 1 □ Emergency Contact

Name ______________________ Relationship ______________ Phone: ______________
Address ______________________ Cell: ______________
Email ______________________ Other: ______________

Check all that apply: □ Responsible Party: Financial □ Responsible Party: Health Care □ Emergency Contact 1 □ Emergency Contact

CERTIFICATION & SUBMISSION OF APPLICATION

The undersigned persons represent(s) that the information contained on this application form and any attached documents are true to the best of his/her/their knowledge and belief. The undersigned persons understand that Jennings will rely upon such information, and agree that any misrepresentation or material omission made by the undersigned persons in connection with this application may result in the denial of the application, the future discharge of the resident, or possible legal action against the undersigned persons.

The undersigned person(s) grant Jennings, its employees and representatives permission and authority to consult with any health care institutions, government agencies, or other entities or persons that may have information concerning the applicant's qualifications for admission and/or the information provided in this admission application. The undersigned person(s) further authorize and request all persons and entities possibly having information relevant to the applicant's qualifications for admission or the material in this application to supply such information to Jennings.

The undersigned person(s) extend immunity to and hereby release Jennings and any persons or entities from any and all liability arising out of the release of information, including otherwise privileged or confidential information. Photocopies of this release will be as binding as the original. The undersigned person(s) warrant that they can legally give the consent and authorizations made above.

Applicant 1 Signature ______________________ Date ______________

Applicant 2 Signature ______________________ Date ______________

If individual other than applicant is completing the application, please sign below:

Print Name ______________________ Relationship to applicant(s) ______________

Signature ______________________ Date ______________

Please use this blank page for any additional notes.

Jennings

Brecksville: 8736 Brecksville Road; Brecksville, OH 44141
Garfield Heights: 10204 Granger Road, Garfield Heights, Ohio 44125
Phone: (216) 581-2900 | Fax: (216) 472-2693

PHYSICAL FORM

Patient's Last Name	First Name	MI	Sex: ☐ M ☐ F	Age	Date of Birth

Patient's Address	Phone No.

Relative/Guardian Name	Address	Phone No.
1.		
2.		

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Medical Diagnosis

Height: _____ Weight: _____

History of weight changes, please explain:

MEDICATIONS (drug, dose, frequency, route)

TREATMENTS

Dressings: _____

Aerosols/O2: _____

Foley Catheter: Size: _____ Irrigation: _____

G-Tube: _____

PROGNOSIS (circle one): Good Fair Poor Terminal

Therapy Needs: Physical_____ Occupational_____ Speech_____

REHABILITATION POTENTIAL:_____ Good _____ Fair _____Poor

PAST HISTORY

Medical:_____

_____

_____

Surgical: _____ Date: _____

_____ Date: _____

Fracture: _____ Date: _____ How Repaired?_____

PHYSICAL FINDINGS Date: _____

Eyes: _____ Nose & Throat:_____

Hearing: _____ Extremities:_____ Decubiti: _____

Teeth: _____ Dentures: _____ Skin:_____

Heart: _____ Pulse: _____ Lungs: _____ Pelvic:_____ Hernia: _____

Blood Pressure:_____ Temp.: _____ Abdomen: _____ Rectal:_____

Bowel & Bladder Condition:_____

Known Allergies:_____

DATE	PERTINENT LABORATORY RESULTS	DATE	PERTINENT LABORATORY RESULTS
_____	CBC:_____	_____	TOTAL PROTEIN:_____
_____	HCT & HGB:_____	_____	BUN:_____
_____	URINALYSIS: _____	_____	EKG: _____
_____	FASTING BL. SUGAR:_____	_____	EEG: _____

Date of Last Chest X-Ray: _____ Results:_____

History of T.B. ☐ Yes ☐ No Date: _____ Treatment: _____

Immunization Dates: Tetanus:_____ Flu: _____ Pneumovax: _____ Shingles:_____

Other(s), please note: _____

PATIENT INFORMATION

Self Care Status: (Check 1 level of ability.) Key: **I** - independent, **A** - needs assistance, **U** - unable to do. Write **S** if needs supervision only.
Draw line across if inapplicable.

ACTIVITY	I	A	U	
Bed Activity				Turns Sits
Personal Hygiene				Face, Hair, Arms Trunk, Perineum Lower Extremities Bladder Program Bowel Program
Dressing				Upper Extremities Trunk Lower Extremities Appliance, Splint
Transfer				Sitting Standing Tub Toilet
Locomotion				Wheelchair Walking Stairs

ADDITIONAL PERTINENT INFORMATION

(Explain necessary details of care, diagnosis, medication, treatments, prognosis, teaching, habits, preferences, etc.)

Glasses _____ Hearing Aid _____
Dentures _____ Contact Lenses _____

Colostomy_____ Cane_____ Wheelchair _____
Prosthesis _____ Walker _____ Recliner Chair_____

BED

Pressure Relieving Mattress ☐Yes ☐No
Other: _____
Transfer Aide?: ☐Yes ☐No

BEHAVIOR

_____ Cooperative _____Agitated
_____ Noisy _____Suspicious
_____ Withdrawn _____Wanders
_____ Aggression

MENTAL STATUS

_____ Alert_____Forgetful _____ Confused
Psychiatric Evaluation ☐ Yes ☐No

COMMUNICATION ABILITY

☐ Yes ☐No Can speak
☐ Yes ☐No Can write
☐ Yes ☐No Understands speaking
☐ Yes ☐No Understands writing
☐ Yes ☐No Understands gestures
☐ Yes ☐No Understands English
If no, state language spoken:_____

DIET

Regular:_____Soft:_____Pureed: _____
Liquids _____

No Conc. Sweets: _____Diabetic I: _____

Diabetic II:_____Supplements:_____

_____

Feeds Self:_____Needs Help: _____
Part:_____All:_____

TUBE FEEDING

Product: _____
Amount: _____Frequency: _____
Type of Tube:_____
Date of Insertion_____
Other: _____
_____
_____

SOCIAL INFORMATION

(Adjustment to disability, emotional support from family, motivation for self care, socializing ability, financial plan, family health problem, etc.)

Is the patient able to safely self-medicate? ☐Yes ☐No

I have assessed and determined that this patient **has cognitive challenges such that he/she would be best served in a secured neighborhood** and would benefit from the specialized dementia programming on the memory care area. ☐Yes ☐No

To the best of my knowledge, the applicant is not suffering from a contagious disease. ☐True ☐See notes

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S NAME _____ PHONE _____ FAX _____
(please print)

CONTINUATION OF CARE: I will continue care at Jennings ☐Yes ☐No If yes, alternate physician:_____ Phone _____

PATIENT REFERRED TO DOCTOR_____I REQUEST CONSULTATION WITH DOCTOR_____