

Triangle Cross Ranch Pre- Admission Assessment

Please fill out all of the following forms and return to the Triangle Cross Ranch Executive Director. Please be as complete and as accurate as possible. Attach copies of all documents required.

Full disclosure of all previous assessments, diagnoses, treatments, medications, placements, behaviors and health care information is required prior to placement evaluation. You may be asked to provide additional information during the application and evaluation process. Refusal to provide requested information, or withholding information, will end the placement evaluation. If you have any questions during this process, please call the Executive Director at 970-454-2219.

The individual identified below has applied for Admission to Triangle Cross Ranch:

Name _____ DOB _____ SSN# _____

Current Address _____

Telephone number _____

The Colorado Department of Public Health and Environment requires that we complete an assessment of each applicant upon admission and periodically thereafter.

Your opinions are important to us.

As a necessary part of the assessment process we ask that you assist us by reviewing or completing the following questionnaire, identifying or adding any information you feel is necessary.

This assessment must be complete and in the possession of the Executive Director prior to any consideration for any type of residency or respite care.

Thank you for your cooperation and support.

Application and Admission Checklist

Each applicant shall have the following items in place prior to consideration for the 10 day trial period or respite care.

- Complete application
- Documentation from prior placements and all requested documentation concerning behavioral or medical disclosures
- Psychiatric assessment
- Primary diagnosis or secondary diagnosis of mild retardation or brain injury
- Physical assessment
- Complete and current medication list including hard copies of current doctor's orders or prescriptions
- Prescription for a therapeutic diet, prescribed within one calendar year of application
- Exercise directives approved by physician or exercise specialist within one calendar year of application
- Hearing assessment
- Vision assessment
- Provider packet signed and notarized
- Court appointed guardianship papers
- Medical power of attorney papers
- Policy disclosures signed and notarized
- PWS agreements signed and notarized
- Release of Liability signed and notarized
- Co-payment Guaranty Agreement signed and notarized
- Release of Background Information
- Legal/Advance Directives Disclosures
- Authorization to Release Health Care Information signed and dated for each provider
- Initial care plan

The Director, in conjunction with other staff members and appropriate health care professionals shall review the provided information for a period of not less than 7 days before notification of acceptance or denial of the 10 day trial period is made. During this review phase, additional information and releases of additional documentation may be requested by the Director. No applicant shall begin their trial period prior to such a review process.

Application for Admission

Applicant Name _____ Date of this application

DOB _____ SSN# _____ Age _____ M/F

Primary Diagnosis _____ Secondary Diagnosis

Current Address _____ Phone _____

Legal Guardian/Responsible Party

Address _____ Phone

Relationship to Applicant

Emergency Contact (if different from above)

Phone _____

Relationship to applicant _____

Social Worker/Advocate _____ Phone

Physical description

Height _____ Weight _____ Hair _____ Eyes _____

Identifying marks or characteristics _____

Family Background

Father _____ Living? _____

Address _____ Phone _____

_____ Marital status _____

Mother _____ Living? _____

Address _____ Phone _____

_____ Marital status _____

Siblings (include names, ages and addresses.)

Name Age Address

Name	Age	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Others in household

_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Living Situation

_____ With parent or guardian

Name _____ DOB _____ SSN# _____

Please list and describe all current medical concerns or health care issues.

Please list all current medications.

Please list all allergies, including medication allergies.

Please list and describe special medical treatments that you currently must carry out.

List all medical equipment currently in use.

Please give an accounting of the all visits to a physician within the last year, including the reasons for the visits and the treatments or results. Use additional paper if necessary or attach appointment forms.

How would you best describe the individual's behavior and/or mental status?

Alert – Awake and aware

Oriented – knows person, place, time

Confused/disoriented – does not know person, place, time

Cooperative – gets along well with others, follows directions and physician's orders

Uncooperative

Lonely/depressed

Withdrawn – just wants to left alone

Combative – strikes out against others at times

Wanders – at risk for getting lost due to forgetting

Flight risk – deals with stress by running away, refuses to stay on the property

Other special behavior concerns

To the best of your knowledge, could this individual function free of supervision or assistance in a room at this facility? Please state reasons why or why not.

Does this individual qualify for employment off of the facility? Please list the last 5 years of previous employment.

Please check the activities that would interest this individual:

Arts/Crafts Men's/Women's Groups

Bingo Outings/Trips

Card games Senior Center visits

Children/kids Music/Radio

Church/spiritual Books/Reading

Cleaning Rancher Council

Cooking/Baking Shopping

Dancing Sports/Sports TV

Exercise Travel

Games/group games/video TV/Movies

Gardening Volunteering

Group activities Visits with family and friends

Animal interaction Writing

Music Parties/Socials

Please list the household chores that this individual enjoys and/or has experience in doing.

Please list the household chores that this individual dislikes and/or is restricted from doing.
Please describe reasons for the restrictions.

Please describe other activity suggestions and/or concerns.

Please check the items for which this individual requires assistance and provide an explanation for the items that require assistance.

_____ Bathing/
showering _____

_____ Dressing _____

_____ Elimination _____
_____ Continent _____ Incontinent

_____ Hair/Nail
care _____

_____ Shaving _____

_____ Oral care _____ Dentures
_____ Has own teeth

_____ Skin
care _____

_____ Sleep/rest/
waking _____

_____ Mobility Gait Steady
Needs adaptive device
Gait unsteady

_____ Nutritional: _____

Physician prescribed therapeutic diet

Food preferences

Food dislikes

Monitor or encourage food/fluid intake? Explain.

Sensory:

Please check the items for which the individual has a demonstrated impairment, along with a brief explanation of the impairment and treatments or accommodations for this.

____ Vision

____ Hearing

____ Speech

____ Smell

____ Taste

____ Touch

Applicant Signature _____ Date _____

Legal Guardian Signature _____ Date _____

Other Signature _____ Date _____

Relationship to applicant _____

Executive Director Signature _____ Date _____

Informal Hearing Handicap Index

This is an informal assessment to be filled out by family or staff. Please rate the individual on the following scale.

5 = very often 1 = almost never

Rancher's Name _____ Date _____

When this person is with other people, does s/he need to hear better?

5 4 3 2 1

Do staff, family, or friends make negative comments about this person's hearing?

5 4 3 2 1

Does this individual have trouble hearing others if there is a radio or TV playing in the same room?

5 4 3 2 1

Does this individual have trouble hearing the radio or TV?

5 4 3 2 1

How often do you feel this individual's life would be better if s/he could hear better?

5 4 3 2 1

How often is this person embarrassed because s/he does not hear well?

5 4 3 2 1

When the individual is alone, does s/he need to hear better?

5 4 3 2 1

Do people tend to leave this person out of conversations because s/he does not hear well?

5 4 3 2 1

Do people tend to leave this person out of conversations because s/he does not hear well?

5 4 3 2 1

In your opinion, how often does this individual withdraw from social activities (in which s/he ought to participate) because s/he does not hear well?

5 4 3 2 1

Does this individual say “What?” or “Pardon me?” or fail to answer when people first speak to him or her?

5 4 3 2 1

Physician’s Examination

A physician must fill out this form for routine physical exam or provide an in-office form that provides *all* of the following information.

General Data

Name _____ DOB _____ Age _____ Sex _____

Physician _____ Chart
No. _____

Measurements

Temp _____ Height _____ Weight _____ Respirations

Blood Pressure _____ Systolic _____ Diastolic _____ Pulse

Distance Vision: Right 20/ _____ Corrected to 20/ _____ Hearing: Right _____
Left 20/ _____ Corrected to 20/ _____ Left _____

Findings

Normal Abnormal Comments/Observations

Head, face, neck, scalp

Mouth & throat

Ears – internal & external canals

Tympanic membranes

Eyes – general

Ophthalmoscopic

Pupils (motility)

Ocular (motility)

Lungs & chest

Breast

Heart

Vascular system

Normal Abnormal Comments/observations

Abdomen & viscera

Anus & rectum

Endocrine system

Genital-urinary system

Upper extremities

Lower extremities

Feet

Spine & musculoskeletal

Identifying body marks

Skin, lymphatics

Neurologic

Females: Pelvic

Pap Smear

Diagnosis

Summary

Surgeries

Hospitalization/institutionalizations

Medications

Attach a list all current prescribed medications & OTC medications. You may use the attached form or an in-office form. All medications including OTC's, PRN's and Vitamins REQUIRE a physician's prescription and hard copies of all medications must be attached.

Is the individual able to self-administer medication? Yes No

What assistance is needed?

Please attach a doctor's order for self-administration of medication if applicable.

Immunizations – *Please attach the most recent copy of the individual's immunization record.*

Date of last tetanus shot _____

Blood work:

Hepatitis C _____ HIV _____ Other _____

Please attach copies of the latest blood screenings.

Date of last TB test _____ Pos/Neg _____

Diet restrictions – Please attach a copy of a doctor’s order for a therapeutic diet or diet restrictions.

All diet restrictions must have a doctor’s order.

Allergies

Physical or mental limitations/restrictions on activity

I have examined _____ and found him/her to be in good health and free from communicable disease.

Physician Name/Title Physician’s Signature

Date _____

Developmental Disability Assessment Snapshot

A physician and other health professional must fill out this form and/or provide an alternate form from the professional’s office that addresses each of the following areas. Please include all contact information for the assessing health professionals. Complete assessment profiles must be attached.

1. IQ and Psychological tests.

IQ: _____ Date tested _____

Test used: _____

2. Psychological test results:

3. Psychological diagnosis if any:

4. Primary diagnosis of developmental disability

5. Secondary diagnosis

6. Additional diagnoses

7. Etiology and dates of disability

8. Suggested treatment and management of disability

9. Limitations and restrictions of disability

Physician Name _____ Signature

Address _____ Telephone _____

Psychiatrist Name _____ Signature

Address _____ Telephone _____

Legal Guardian/Parent Signature

Medication List

Please provide a complete list of all prescription medications and all over-the-counter (non-prescription) medications (vitamins, antacids, cold medicines, pain relievers, topical preparations, etc.) **Please attach hard copies of all physicians' orders for all medications.**

Rancher Name _____ Date

Physician's Name _____ Date

Address _____ Phone

Prescription for a Therapeutic Diet

_____ has been prescribed the following therapeutic diet, specific to his/her diagnosis of Prader-Willi Syndrome.

- Restrict access to food via locking devices and alerts.
- _____ calorie limit per day.
- _____ daily incentive calories allowed based on adherence to the attached exercise program.
- _____ This diet constitutes a weight loss diet.
- _____ This diet constitutes a weight maintenance diet.

The ideal weight/target weight for this individual is

_____.

Professional follow up to be conducted every _____ weeks/months.

 Prescribing Physician

Approved Exercise Program

The following exercise program has been designed for
_____ and is specific to his/her diagnosis of Prader-Willi
Syndrome.

Please describe below in detail the daily activities as well as any incentives that may be offered for completing the program on a daily basis.

Professional follow up shall be conducted every _____ weeks/months.

Professional approving program Title Date

Release of Background Information

All current and prospective Ranchers, staff and volunteers are subject to an annual criminal history record check. Our review of your records may include the following:

- Criminal record
- Driving record
- Character references
- Employment references
- Social Security number
- Employment verification
- Education records

By signing and providing the information requested, you acknowledge and agree to allow Triangle Cross Ranch to obtain, verify and review the information you've provided as well as information in the records accessed as the result of the background and reference information checks. If after reviewing the information received, Triangle Cross Ranch determines that some of the data adversely affects your status here, you will be given a "pre-adverse action disclosure" that includes a copy of the report and an explanation of the law. You will also be given an "adverse action notice" that will contain the name, address and phone number of the background check company we used; a statement that the company we used did not make the adverse decision, rather that the Triangle Cross Ranch Board of Director did. You will also receive notice

that you have the right to dispute the accuracy or completeness of any of the information received.

Please provide the following information so that we may accurately submit our requests for information.

Printed name: _____

Maiden name: _____

Social Security number: _____

Date of Birth: _____

Signature: _____

Today's Date: _____

Legal/Advance Directives Disclosures

Rancher Name: _____ Date: _____

Please identify the legal arrangements that have been made on behalf of the above named individual:

- _____ Court Appointed Guardianship
- _____ Guardianship ad litem
- _____ Financial Conservatorship
- _____ Living will
- _____ Medical Durable Power of Attorney
- _____ Medical Proxy
- _____ DNR Directive

Please attach copies of all legal documentation for the above named items. Triangle Cross Ranch cannot recognize the legal authority of these arrangements without proper documents to back them up.

Signatures of individuals who completed this form:

Rancher's Signature: _____ Date: _____

Legal Guardian: _____ Date: _____

Parent/Responsible Party: _____ Date: _____

Other Signature: _____ Date: _____

Relationship to Rancher: _____ Date: _____

Executive Director: _____ Date: _____

Media Release

From time to time we have the opportunity to use pictures of the Ranch and Ranchers for our website, brochures, newspaper articles and other forms of advertising. Only first names or no names are used in captions. We wish to always follow the direction of the Ranchers and their guardians. Therefore, please complete the attached form that will become part of the Rancher's file.

_____ Yes, you have my permission as Rancher/Legal Guardian to use photos of

_____ for purposes of promoting the Ranch and Ranch activities.

_____ No, do not use photos of _____ for any Ranch

promotional materials.

Rancher signature _____ Date _____

Legal Guardian signature _____ Date _____

Authorization to Release Health Care Information

Please make as many copies as necessary. Each facility or provider will require a signed copy.

Patient's Name _____ Date of Birth _____

Previous Name _____ SSN# _____

I request and authorize _____ to release health
care information of the patient named above to

Facility _____

Address _____

City _____ State _____ Zip _____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, circumstances or
dates:

_____ All health care information

_____ Other

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV, AIDS and gonorrhea.

_____ I authorize the release of my STD results, HIV/AIDA testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

_____ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient signature _____ Date _____

Legal guardian _____ Date _____

Other signature _____ Date _____

Relationship to patient _____

Individualized Care Plan Goals and Objectives

This form is the first step in developing an individualized care plan for the applicant. It is for the family and applicant to use together in clarifying the primary reasons for placing their family member at Triangle Cross Ranch and visualizing their expectations of the Ranch staff.

Please identify the behaviors and/or results you would like to see related to residency at Triangle Cross Ranch and participation in its programs. Staff will help with this process if you find it difficult.

Rancher Date

Goal

Objective

Objective:

Objective

Staff Support

Evaluation
