The Stewart Community Home, Inc.

1125 15th Street
Columbus, Georgia 31901
706-327-2707
Fax 706-327-9507

MISSION STATEMENT

The Stewart Community Home, Inc., is a non-profit Personal Care Home in the Chattahoochee Valley that provides permanent and transitional safe-housing for disabled adults requiring limited care. We promote personal independence while offering a variety of supportive services and watchful oversight 24-hours a day, 7 days a week, and 365 days a year. These services are provided regardless of the ability to pay. We offer nutritious meals, medication oversight, case management, and recreational activities.

ADMISSION CRITERIA

1. Must be 18-years of age or older.
2. Must have a documented diagnosis of disability (mental or physical).
3. Must be ambulatory or able to transfer and be mobile without requiring assistance.
4. Must require minimal or limited supervision.
5. Cannot require skilled nursing services.
6. Cannot be violent or combative.

REQUIRED DOCUMENTATION PRIOR TO ADMITTANCE

1. Complete Physical Exam, no older than 30-days prior to admission.
2. PPD/TB test or chest x-ray, if necessary, no older than 30-days prior to admission.
3. Negative COVID-19 test.
4. Current social and medical history, to include statement of STDs or any communicable disease history.
5. Current psychological evaluation/examination.
6. Current Medication list.
7. Copies of Medicare and/or Medicaid card, insurance cards, and Social Security card.

For more information, or to set up an intake interview, please call 706.327.2707.

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Name of Applicant: _____ Date of Referral: _____

Please circle yes or no.

- Does the applicant have a criminal history? YES NO
- Does the applicant have a psychiatric history? YES NO

Circle the appropriate status:

Ambulating	Bathing	Dressing	Eating
Independent	Independent	Independent	Independent
Needs Supervision	Needs Supervision	Needs Supervision	Needs Supervision
Needs Assistance	Needs Assistance	Needs Assistance	Needs Assistance

Grooming	Skin Integrity	Toileting	Transferring
Independent	No pressure sores	Independent	Independent
Needs Supervision	Stage 1	Needs Supervision	Needs Supervision
Needs Assistance	Stage 2	Needs Assistance	Needs Assistance
	Stage 3	Requires Adult briefs	

Does the applicant receive disability benefits? YES NO

Is the applicant a veteran? YES NO

Referring Agency: _____

Name of person referring: _____

Contact number: _____

The Stewart Community Home, Inc.

APPLICATION FOR ADMISSION

Applicant refers to the individual being considered for residency

Date: _____

Application completed by: _____ Relationship: _____

Applicant Name: _____ DOB: _____ Age: _____

Applicant's Present Residence (Check one): __Home __Homeless __Group Home __Other

Street: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Race: _____ Gender: _____

Applicant's Marital Status (Circle one):

Married Single Divorced Widowed Co-Habitation

Education Level (Circle one):

Never finished High School High School Graduate GED College

Highest Grade Completed: _____ College Degree: _____

Special Education Classes Attended: _____

Veteran Status (Circle one): YES NO

Branch: _____ Years Served: _____

Do you drink alcohol (Circle one)?

NEVER OCCASIONALLY SOMETIMES ALL THE TIME

Do you do drugs? YES NO Have you ever had a drug problem? YES NO

Have you ever been arrested? YES NO

What was the crime? _____

Are you on probation? YES NO Are you on Parole? YES NO

The Stewart Community Home, Inc.

APPLICATION FOR ADMISSION

Name of Applicant: _____

Name of Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

May we contact the Emergency Contact and discuss applicant's issues/conditions while residing in the home? YES NO

Religion: _____ Church Attended: _____

Please explain why you are in need of placement_____

_____

_____

_____

_____

_____

What are your goals? _____

_____

_____

_____

_____

_____

_____

Completed by: _____ Date: _____

MEDICAL INFORMATION

Name of Primary Care Physician:
_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Last visit with this physician: _____

Name of Psychiatrist: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Last visit with this physician: _____

Please list past/present physical and/or mental illnesses: _____

_____

_____

Current Medications: _____

_____

_____

Allergies: _____

_____

Completed by: _____ Date: _____

PLACEMENT HISTORY

Hospitalization(s) within the last 12 months:

Date of Hospitalization: _____ Hospital: _____

Reason for hospitalization: _____

Date of Hospitalization: _____ Hospital: _____

Reason for hospitalization: _____

Date of Hospitalization: _____ Hospital: _____

Reason for hospitalization: _____

INCOME/INSURANCE INFORMATION

INCOME:			AMOUNT:
SSI Benefits:	YES	NO	$_____
SSDI Benefits:	YES	NO	$_____
VA Benefits:	YES	NO	$_____
Other Benefits:	YES	NO	$_____

INSURANCE:

Do you have Medicaid? YES NO If so, Medicaid number? _____

Do you have Medicare? YES NO If so, Medicare number? _____

Completed by: _____ Date: _____

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VERIFICATION OF HOMELESSNESS
(if applicable)

Homeless persons are those who are sleeping in shelters or in places not meant for human habitation, such as cars, parks, sidewalks, or abandoned buildings. Such persons who spend a short time (30 consecutive days or less) in a hospital or other institution will still be considered homeless upon discharge from the facility. To avoid trauma and disruption caused by sleeping on the street or in a shelter, a person will also be considered homeless if (1) they are being evicted within the week from dwelling units or are persons to be discharged within the week from institutions in which they have been residents for more than 30 consecutive days; and (2) no subsequent residencies have been identified; and (3) they lack the resources and support networks needed to obtain access to housing. Keeping this information in mind, in order for the applicant to be considered homeless, he/she must provide verification of the type of living space or statement from the resident or referral agency about the resident's previous living place or statement from the resident's family members that the resident can no longer reside with them or is being evicted from a family member's residence.

Please review the following eligibility standards and indicate by way of check which category the applicant falls under. Provide all documentation to verify the category chosen.

_____ Person coming from the streets
NOTE: These applicants would be people who have been living in public or private places not designed for or ordinarily used as regular sleeping accommodations (i.e. on the street, in cars, or other inappropriate places), Stewart Community Home will verify this type of living condition by information obtained during the intake process, which may include names of other organizations or outreach workers who have assisted the applicant in the past, names and addresses of friends and/or relatives, any general assistance checks the applicant has received, the check delivery address, or any other information regarding the activities in the recent past which might provide a means of verification. If verification cannot be found by the previous mentioned means, a short written statement will need to be prepared stating the applicant's previous living conditions and signed and dated by the applicant.

_____Persons coming from emergency shelter or referral agency
NOTE: Applicants coming from a shelter are to submit a written verification from that shelter's staff. A record of this verification will be filed and dated. Applicants referred from other agencies should submit written verification (i.e. intake forms) from the referring organization's staff as to where the applicant has most recently been living. This verification information will be dated and filed.

_____Persons coming from transitional housing
Note: Applicants who come from a transitional housing facility must have a written verification from that facility's staff that the applicant lived on the streets or in an emergency shelter prior to living in the transitional facility. A record of this verification will be dated and filed.

Completed by: _____ Date: _____

The Stewart Community Home, Inc.

Authorization for Release of Information

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

OR

b. all past, present, and future periods.

3. Extent of Authorization

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. 8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

_____

Date

05.7.2019

Healthcare Facility Regulation Division

PHYSICIAN'S MEDICAL EVALUATION FOR ASSISTED LIVING OR COMMUNITY LIVING

Name of Patient	**DOB**	**Height**
Present Address		**Weight**

City	**State**	**Zip**	**Telephone**

REASON FOR EVALUATION: (Circle one)
Pre-Admission Annual Possible change in patient's condition Other (Describe)_____

1. Current Diagnosis(es)

2. Physical Limitations

3. Mental Health Limitations

4. Treatment/Therapies (Describe medical services or nursing care or treatment needed.)

5. Supportive Services Needed

6. Allergies

7. DIET INSTRUCTION: (Circle One) Regular No added table salt No concentrated sweets
Other_____

8. STATUS OF THE FOLLOWING: (Circle appropriate answers)

AMBULATING	BATHING	DRESSING	EATING
Independent	Independent	Independent	Independent
Needs supervision	Needs supervision	Needs supervision	Needs supervision
Needs assistance	Needs assistance	Needs assistance	Needs assistance
Needs total help	**Needs total help**	**Needs total help**	**Tube feeding**
Bedridden			

GROOMING	SKIN INTEGRITY	TOILETING	TRANSFERRING
Independent	No pressure sores	Independent	Independent
Needs supervision	Stage one	Needs supervision	Needs supervision
Needs assistance	Stage two	Hygiene assistance	Needs assistance
Needs total help	Stage three	Adult briefs	Needs total help
	Stage four	Catheter care assistance	
	Location _____	Ostomy	

RESTRAINTS

Requires no restraints	Requires chemical restraints	Requires physical restraints
	Type_____	Type_____

9. CIRCLE THE APPROPRIATE ANSWER IN EACH STATEMENT BELOW.

a. The individual HAS or HAS NOT received screening for TB and the individual HAS DOES NOT HAVE signs and/or symptoms of infectious diseases which are likely to be transmitted to other residents or staff.
TB SCREENING INFORMATION: Date:_____ Results:_____

b. The individual's behavior DOES or DOES NOT pose a danger to self or others. If DOES, please explain. If medications are necessary to control behavior, please explain. _____
_____

c. The individual DOES or DOES NOT require assistance from staff during the night. If assistance is required, please explain._____
_____

d. The individual DOES or DOES NOT require 24-hour nursing supervision.

e. The individual DOES or DOES NOT require placement in a specialized memory care unit (unit with controlled access/egress designed to serve residents who are at risk of engaging in unsafe wandering activities or other unsafe behaviors).

10. MEDICATIONS: List all medications including over the counter medications, herbal remedies, topical medications, vitamins, etc. Any PRN medications must include instructions, i.e. parameters for use.

MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE	NEEDS HELP WITH ADMINISTRATION YES	NO

MEDICAL CERTIFICATION SIGNATURE REQUIRED:
Assisted living facilities/personal care homes ARE NOT permitted under the law to provide medical, skilled nursing or psychiatric care. In your professional opinion, can this patient's needs be safely met in an assisted living facility/personal care home? YES: _____ NO:_____

COMMENTS:

SIGNATURE OF PHYSICIAN, PA OR NP:	DATE:
PRINTED NAME OF PHYSICIAN, PA OR NP	GEORGIA LICENSE #
ADDRESS OF PHYSICIAN, PA OR NP	

CITY	STATE	ZIP CODE

PLEASE RETURN COMPLETED FORM TO:

CONTACT PERSON	FACILITY NAME
ADDRESS	PHONE:

CITY	STATE	ZIP CODE

The Stewart Community Home, Inc.
PRN Medication Consent

Name: _____ DOB: _____

1. Extra Strength Tylenol (Acetaminophen) 325/500 mg – Take 2 tablets every 6 hours as needed for headache, fever, muscle aches, arthritis, backaches, the common cold, toothaches, and menstrual cramps. Do not exceed more than 6 tabs in 16 hours.

2. Extra Strength Rolaids (Antacid – calcium 270 mg and magnesium 60 mg) tablets – Chew 4 tablets hourly as needed for heartburn, sour stomach, acid indigestion, or upset stomach due to these symptoms. Do not exceed more than 10 tablets in a 16-hour period.

3. Docusate Sodium (Colace) 100 mg soft gel caps – 2 caps daily as needed until first bowel movement. Do not exceed more than 2 caps in a 16-hour period.

4. Tussin DM (Robitussin) cough syrup – 2 tsp. every 4 hours as needed for cough relief and loosening of mucus to make coughs more productive. DO not exceed 4 doses in a 16-hour period.

5. Diphenhydramine HCl (Benadryl) 25 mg – Take one to two tablets every 4 to 6 hours as needed for sneezing, itchy/watery eyes, runny nose, and itching of the nose or throat. Do not exceed more than 3 doses in a 12 hour period.

6. Zyrtec (Cetirizine HCl) 10 mg - Temporarily relieves these symptoms due to hay fever or other upper respiratory allergies: runny nose, sneezing, itchy/watery eyes, and/or itching of the nose or throat. Do not take more than one 10 mg tablet in 24 hours.

7. Claritin (Loratadine) 10 mg - Temporarily relieves these symptoms due to hay fever or other upper respiratory allergies: runny nose, itchy/watery eyes, sneezing, and/or itching of the nose or throat.

8. Maximum Strength Bismuth Subsalicylate (Pept-Bismol) – 2 Tbsp. every hour as needed for upset stomach, indigestion, heartburn, nausea, and diarrhea.
   DO not exceed 6 Tbsp. in 6 hours.

9. Imodium (Loperamide HCl) 2 mg – 2 soft-gels after the first loose stool; 1 soft-gel after each subsequent loose stool; but no more than 4 soft-gels in 24 hours. Controls symptoms of diarrhea, including Travelers' Diarrhea.

10. Calamine (Caladryl) lotion – Moisten cotton or soft wash cloth with lotion and apply 3 times daily as needed for comfort to dry the oozing and weeping of poison ivy, poison oak, and to help soothe the itching of insect bites. Do not exceed more than 3 uses daily.

11. Triple Antibiotic Ointment (Neosporin) – Clean affected area and apply a small amount (equal to surface area of tip of finger) on area 1-3 times daily as needed for infection prevention in minor cuts, scrapes, and burns. Do not exceed more than 3 applications daily.

12. Ambesol gel – Apply pea-sized amount to affected area(s) 4 times daily as needed for temporarily relieving pain associated with toothaches, sore gums, canker sores, minor dental procedures, and dentures. Do not exceed more than 4 uses in a 16-hour period.

13. Aspercreme (Trolamine salicylate 10%) - Apply generously to affected area, massage into painful area until thoroughly absorbed into skin. Repeat as necessary, but no more than 4 times daily. Temporarily relieves minor pain associated with arthritis, simple backache, muscle strains, sprains, bruises, and cramps.

See next page

The Stewart Community Home, Inc.

PRN Medication Consent

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Name: _____ DOB: _____

14. Other OTC medications and dosages as recommended by physician:_____
_____
_____
_____

15. Vitamins and dosages as listed by physician: _____
_____
_____
_____

**Generic products may be substituted. ** ____ YES _____ NO

Renew or Discontinue by: _____

Special Instructions: _____
_____
_____
_____

Physician Signature: _____ Date: _____

Physician Name (Printed): _____