Form#650.E

Esther's Home, LLC

Phone: 703-623-5275

Email: esthershomellc@gmail.com

Initial Assessment Form

Initial Contact Date:	**Method of Screening:** **□ Phone □ Face to Face □ Other**
Screening Employee's name:	

IDENTIFICATION BACKGROUND

(*All questions on this form must be answered-write N/A if not applicable)*

Last Name: **First Name:** **MI:**	**Date of Birth:**	**Social Security No.:**	
Address:	**City:**	**State:**	**Zip Code:**
County:	**Home Phone:**	**Work Phone:**	**Other:**
Gender: □ Male □ Female		**Marital Status:** **□ Single □Married □Divorced □Separated □Widowed**	

EMERGENCY CONTACT/PRIMARY CAREGIVER/PHYSICAN

Name:	**Relationship:**
Address:	**Phone Numbers:** **(H):** **(W):**
Name:	**Relationship:**
Address:	**Phone Numbers:** **(H):** **(W):**
Name of Primary Physician:	**Phone Numbers:** **(H):** **(W):**
Address:	
Initial Contact **Name of Person who Called:**	**Relationship to Applicant:**
Phone Numbers: (H):	**(W):**

PHYSICAL HEALTH ASSESSMENT

Present Need/Problem/Diagnosis
Diagnosis: *check areas there is a need for services:* □ Residential □Day Support □ Transportation □ Vocational Training □ Money Management □Physical Health □Medication □ Other (specify):
Psychiatric Needs: (include current and pass counseling or psychiatric services and hospitalizations (List precipitating factors). Attach any psychological, psychiatric and neurological exams and reports available:
Current Medical Problems: (List past serious illnesses, infectious diseases, serious injuries and non-psychiatric hospitalizations):

Onset and duration of medical conditions:

Professional Visits/ Medical Admissions			
Doctor's Names	**Phone**	**Date of Last Visit**	**Reason for Last Visit**

Physician Review:

Is a physical examination completed and signed by a licensed physician in the last 12 months attached?

_____YES _____NO, psychical examination must be taken by licensed physician

Comments:

History of Medical Care in the past 12 months, have you been admitted for medical or rehabilitation reasons:

Yes	No	Place:	Name of place:	Date Admitted:	Length of Stay/Reason:

		Hospital			
		Nursing Facility			
		Adult Care Residence			

Physical Needs of Applicant: (please check all that apply):

□ Wheelchair □ Braces □ Helmet □Walker □Toilet Chair □ Shower Chair □ Other (specify):

Speech:

□ Speech Understandable □ Sign Language/ Gestures/ Device □ Does not Communicate □ Other (please specify):

Vision: □ Adequate □Impaired □ Legally Blind □ Wears Glasses □Wears contacts

Hearing: □ Hearing adequately □Hearing Loss □Hearing Aid □ No Hearing () Other:

Do you have seizures, convulsions with high temperatures, fainting spells, or staring spells? If so, describe and make a note of special instructions to be followed in the event that this happens (attach protocol from physician if applicable):

Do you have any known problems that make it difficult to eat?

Yes	**No**		**Yes**	**No**	
		Food Allergies			**Problem swallowing**
		Inadequate food/fluid intake			**Taste problems**

		Nausea/Vomiting/Diarrhea			**Tooth or mouth problems**
		Problems eating certain foods			**Other (explain):**

Explanation (if yes to any above):

Special Diet: □ None □ Low/Fat/Cholesterol □No/Low Salt □ No/Low Sugar □Combination/Other

Comments:

Do you take dietary:

□ None □ Occasionally □ Daily, not primary source □Daily, primary source

□Daily, Sole Source

Comments:

Do you have a substance use or abuse history? □ Yes □ No If yes, please explain:

CURRENT MEDICAITONS

Drug Name (prescriptions and over-the-counter):	**Dose:**	**Frequency:**	**Route:**	**Reasons Prescribed/Prescribing Physician:**

Total No. of Medicines:			**Total No. of Psychotropic Drugs:**	
Do you have any problems with medication(s)? □ Yes □ No **If yes, explain:**				
At risk behavior to self and/or others? () Yes () No If yes, Explain:				

Method of Screening	**Screening Recommendations**	**Disposition of Individual**

Applicant's Name:	**Social Security No.:**

I hereby apply for services of Esther's Home, LLC, LLC and Behavioral Health and Developmental Services for me as a client or for the above named person to whom I am the legal authorized representative to act in his/her behalf.

I understand that use and disclosure of my information is governed as set out in the Privacy Notice that has been provided to me.

I understand that in the event of a medical emergency, qualified medical personnel will be contracted to administer appropriate medical treatment. I acknowledge that if I am admitted, my application will be included in my records and will be destroyed ten years after discharge. I also acknowledge that if I am not admitted, my application will be retained for six months.

As part of your comprehensive assessment, it is recommended that you provide documentation of a current medical examination. You are asked to arrange this through your physician. If you do not have a physician, you may request help in obtaining one. You have the right to decline this request and this will not affect the services that we will provide. I will comply with this recommendation and provide documentation of examination ___**YES** ___**NO**
Signature of Applicant: **Date:**
Signature of Legally Authorized Representative: **Date:**
Signature of QDDP: **Date:**

Form#240A

Esther's Home, LLC

Phone: 703-623-5275

Email: esthershomellc@gmail.com

Resident Financial Information

Resident's Name:	Date of Birth:	Medicaid #:
Address:		Phone#:
Does the individual have a Representative Payee: □Yes □ No	Rep. Payee Name:	Rep. Payee Contact #:
Address of Rep. Payee:		
Does the individual require assistance with managing their funds: □Yes □ No		
Banking Institution:		Checking #: Savings #:
Does the individual receive: □ SSI: $_____monthly amount □ SSDI: $_____ monthly amount □Payroll: $_____monthly amount Employer's Name _____ Address: _____		

Balance upon Entering Program: $ _____

Form# 740

Esther's Home, LLC

Phone: 703-623-5275

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ADULT HISTORY AND ANNUAL PHYSICAL FORM

NAME: _____ DOB: _____ TODAY'S DATE: _____

MEDICATIONS (including OTC &herbs):		
Name:	**Mg./Dosage**	**Reason why you are taking them?**

If you have more medications or medical history that cannot fit on the form, please write on the back of the form

LOCAL PHARMACY	**PAST MEDICAL HISTORY** **DATE**
ADDRESS:	**1.**
PHONE#:	**2.**
MAIL ORDER PHARMACY:	**3.**
Address:	**4.**
City/ST/Zip:	**5.**
Phone#: **Member ID#:**	

Have you ever been hospitalized or had an operation? YES NO If you, please explain with type of surgery and dates:

Adult Immunizations Review-Please list the date of your last immunization (write N/A if not applicable):

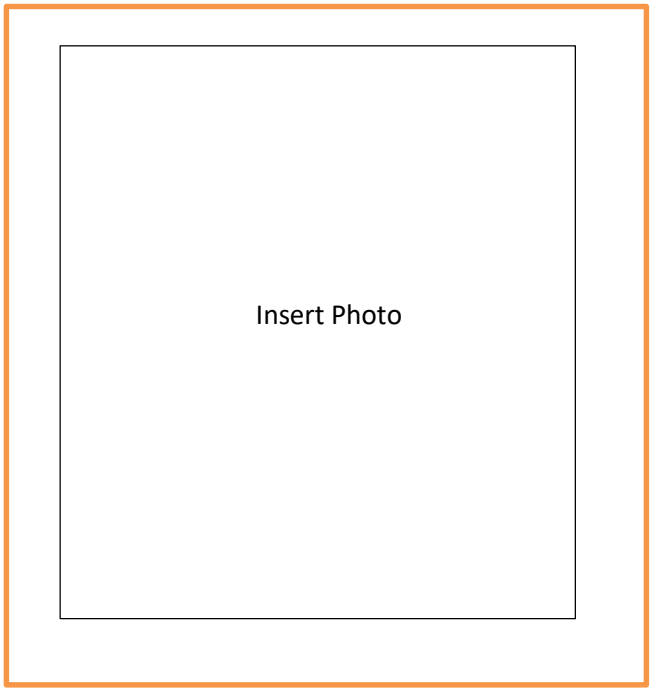
Flu: _____ Pneumonia: _____ Shingles: ____TDaP (Tetnaus, Ditptheria &Pertussis): _____

REVIEW OF SYSTEMS:

Mark (X) if you have any of these conditions currently or in the past. If no medical complaints please circle : None

	Present	Past		Present	Past		Present	Past
1. General			**6. Cardiovascular**			**9. Musculoskeletal**		
Weight Loss			**Chest Pain**			**Joint Pain**		
Fatigue			**Irregular Heartbeat**			**Joint Swelling**		
Memory Loss			**Elevated Blood Pressure**			**Jaw Pain**		
			Heart Disease			**10. Neurological**		
2. HEENT			**Shortness of Breath**			**Blackouts**		
Headache			**Swelling of limbs**			**Dizziness**		
Visual Loss						**Seizures**		
Decreased Hearing			**7. Endocrinology**			**Stroke**		
Sinus Pain			**Diabetes**			**11. Psychiatric**		
Hoarseness			**Excessive Thirst**			**Anxiety**		
Sore Throat			**Excessive Urination**			**Depression**		
Trouble Swallowing			**Libido Change**			**Sleep Issues**		
3. Respiratory			**8. Gastrointestinal**			**12. Male/Genitourinary**		
Cough			**Bloody Stool**			**Urinary Dribbling**		

CLIENT FACE SHEET FORM



Date of Photo:

Date of Birth:

Name:
Address
City/St:

Phone:
Fax:
Cell Phone:

Residential Provider Emergency Contact:
Name:
Phone:
Pager:

Residential Manager
Name:
Phone:
Pager:

Sex: **Height:** **Weight:**
Race: **Hair Color:** **Eye Color:** **Religion:**

Advance Directive:
Allergies:
Other General Physical Characteristics:
Ability to Protect Self:
Adaptive Equipment:
Language/Communication Capabilities:
Marital Status:
Legal Status:
History of Substance Abuse:
Significant Behavioral Characteristics:

Parents/Guardian/Involved Family

Legal Guardian:
Address: *City/State/Zip:* *Phone:*

Name:
Address: *City/State/Zip:* *Phone:*

Name:
Address: *City/State/Zip:* *Phone:*

Name:
Address: *City/State/Zip:* *Phone:*

Name:
Address: *City/State/Zip:* *Phone:*

Name:
Address: *City/State/Zip:* *Phone:*

Name:
Address: *City/State/Zip:* *Phone:*

Other Contact Details

Pharmacy Name:
Address: *City/State/Zip:* *Phone:*

Group Day Support Program Name:
Address: *City/State/Zip:* *Phone:*

Day Support Manager Name:
Address: *City/State/Zip:* *Phone:*

PCP/Specialists	*Name*	*Address*	*City/State/Zip*	*Phone*
Psychiatrist				
Dentist				

Primary Care Physician

Known medical conditions:

Insurance: **I.D. Number:**

Prescription	Strength	Time(s) Taken	Dosage	Route

Completing Form: _____ _____
Signature/Title Date

2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Parent/Guardian/Client

Signature: _____ Date: _____

Print: _____

Witness:

Signature: _____ Date: _____

Print: _____

Esther's Home, LLC

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AUTHORIZATION TO TRANSPORT

The following client, _____ has permission to be transported to and from activities by Esther's Home, LLC staff members. This authorization is in effect for the time that services are provided by **Esther's Home, LLC.**

When under our supervision, Esther's Home, LLC staff will exercise our best judgment and observe normal precautions. Nevertheless, unforeseeable situations may arise that would require your client to be treated medically on an emergency basis. In such a case, we will make every possible attempt to reach you before making any decisions. However, in the event that we are unable to reach you, we are asking for your permission to seek medical care on behalf of the above named client.

- ☐ **I acknowledge that I have read and/or had the information above explained to me by Esther's Home, LLC Staff.**
- ☐ I agree to release **Esther's Home, LLC**, and any licensed medical facility or physician from liability resulting from an incident or when providing emergency medical treatment becomes necessary for the welfare of the above name client.

Signature: _____ Date: _____

Print: _____

Esther's Staff Signature:

Signature: _____ Date: _____

Print: _____

Form# 570

Esther's Home, LLC

Phone: 703-623-5275

Email: esthershomellc@gmail.com

MISSION STATEMENT

Mission Statement:

Esther's Home, LLC is founded on principles of making a difference in the lives of individuals by providing creative supports and opportunities that facilitate the meaningful interaction integration, autonomy, and personal preferences of individuals diagnosed with development disabilities within their respective community through engagement and coaching.

Philosophy:

Esther's Home, LLC provides community living waiver to individuals with disabilities and access to Community Life Engagement and Community Coaching activities that may include volunteer work; post-secondary, adult or continuing education; accessing community facilities such as a local library, gym, or recreation center; participation in retirement or senior activities; and anything else people with and without disabilities may desire.

Individuals will learn and be educated about making informed choices about their personal interest, community activities, events and community resources which we believe will assist in the development of their life skills and personal growth. Every individual's talents will be identified by individual assessment with the development of their Person-Centered Support Plan, which will reflect their individual activities and supports of interest.

Community Engagement Services:

Esther's Home delivers services as a non-center based provider for community engagement at a ratio of no more than 1:3 designed to support and foster the ability of the individual to acquire, retain, or improve skills necessary to build positive social behaviors, improve skills to possible employability, interpersonal competence, greater independence and personal choice necessary to access typical activities and functions of community life, using the community as the natural learning environment to increase social inclusion.

Community Coaching Services:

Esther's Home, LLC delivers services as a non-center based provider for community coaching at a ration for individuals who need 1:1 support in order to build a specific skill to address barriers preventing participation in activities of community engagement.

Community Engagement/Community Coaching Program Goals:

1. To provide social networks opportunities with community, family members or others that who have no diagnosed developmental disability.

2. To provide access to public goods and services; recognized as competent; valued social role and trusted to perform social role in community, belong to social networks within which one receives and contributes support
3. To provide activities, social roles and relationship with nondisabled citizens;
4. To provide interaction with other and access to community facilities;
5. To provide activities and supports, which best meet every individual's personal preferences and interest.
6. To create community resources that will provide various opportunities of learning
7. To make a difference in helping all individuals chose a meaningful lifestyle.

Community Engagement and Community Coaching Activities:

Esther's Home, LLC provides non-centered based service activities to Community Life Engagement and Coaching activities to include but not limited to volunteerism and accessing community facilities such as a local library, gym, swimming, senior and retirement activities, and anything else individuals may be interested in. Activities will also include accessing community banks, social security administration and other human service supports. Activities may support career exploration for those not yet working or between jobs, supplement employment hours for those who are working part-time, or serve as a retirement option for older adults.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____