Monarch
Elder Care

236 Broadway Street, Lowell, MA 01854

Application

FAX: 978.455.1963 or Email: monarcheldercare@gmail.com

Date _____

Person Referring/Organization _____

First Name _____M.I._____ Last Name _____

Address _____Apt # _____ City _____Zip_____

DOB___/____/_____ Sex ____ Tel _____Cell_____Religion_____

Place of Birth_____ Languages Spoken _____

Referring person/Organization _____

ID#_____Medicaid#_____HMO#_____

SSN#_____Medicare#_____Other Ins._____

Race: _____American Indians/Alaskan Native _____Asian _____Black/African American

____Asian & White,___Asian & Pacific Islander ____White-Non-Hispanic____Hispanic/Latino

Marital Status:___Never Married,_____Married, ____Widowed, ____Separated, ____Divorced

Spouse Name_____Yrs Married____,___Living ____Deceased___

Living Arrangements: ___Alone ____W/Spouse ____W/Children____W/Relatives ___Others

Medical Information

Primary Care Physician _____Tel#_____Fax#_____

Address _____City _____ Zip _____

Specialist Drs._____

Preferred Hospital:_____Allergy_____

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CURRENT MEDICATION LIST

MED	DOSE	ROUTE	FREQUENCY	MED	DOSE	ROUTE	FREQUENCY

Medical Problem: _____

_____

Is Applicant able to sign documents? ____Yes ___No_____

If No Name of Responsible Person_____Relationship_____

Does applicant have Legal Guardian____Yes ____No If Yes Name Address & Tel No._____

_____

Has the applicant signed a Power of Attorney? ____Yes ___No If Yes Name Address & Tel No

_____

Emergency Contact: Names & Tel No.

Primary Care Giver_____

Second Care Giver_____

Preferred Days of Attendance Circle it: Mon Tues Wed Thurs Fri

Support System Family & Friends

Name	Relationship	Contact Frequency	Help Provided

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Community Support Services used by Applicant (check all that apply)

___ Meals on Wheels___Senior Center___ Senior Transportation ____ Shopping____ Home HHA
____ Respite___ Social Services____ Hospice___ Visiting Nurse ____Others_____

Comments_____

Education: ____Grammar _____High School _____College _____

Employment History:_____

Special Interests:

Current Clubs/Organizations:_____

Preferred Activities _____Alone_____In-group, Special Talents_____

Hobbies or Interests_____

Nutritional Status

Special Diet_____Appetite____Good____Fair____Poor, Favorite Foods_____

Personal Information

	IND	NEEDS ASSIST	UNABLE		IND	NEEDS ASSIST	UNABLE
DRESSING:				**BOWEL FUNCTIONING:**			
Shoes & Stockings				Controlled			
Outer Clothing				Involuntary			
Under Clothing				Constipation			
Diet: Dentures U__ L__				**FUNCTIONAL LIMITATIONS:**			
Feeds Self				Travels Alone			
PERSONAL HYGINE:				In and Out of Car			
Bathing				Walks Unassisted			
Mouth Care				Climbs Stairs			

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Shampoo, Hair Grooming				Transfers chair to toilet			
Shaving				Cane, Crutches, Walker			
Toileting				Manages Wheelchair			
BLADDER FUNCTIONING:				**COMMUNICATION ABILITIES:**			
Continent				Vision			
Incontinent				Hearing			
Catheter Drainage				Speech			

Do you have memory loss? _____Yes _____No

Balance: Walking:_____ Standing:_____ Sitting:_____

Signature of Participant/Responsible Person_____Date_____