STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

IDENTIFICATION AND EMERGENCY INFORMATION

This information is required under the H & S Code and the regulations of the Department to be maintained on every person admitted to a community care facility, to be readily available to the person in charge, but not accessible to unauthorized persons. All information must be kept current. See other side for additional information required for residential facilities for children.

A. ALL FACILITIES [EXCEPT CHILD CARE CENTER/FAMILY CHILD CARE HOME COMPLETES LIC 700]

1. NAME OF CLIENT OR CHILD		SOCIAL SECURITY NUMBER (OPTIONAL)	DATE OF BIRTH	AGE	SEX
2. RESPONSIBLE PERSON OR PLACEMENT AGENCY		ADDRESS		TELEPHONE ( )	
3. NAME OF NEAREST RELATIVE (OPTIONAL)	RELATIONSHIP	ADDRESS		TELEPHONE ( )	
4. DATE ADMITTED TO FACILITY	ADDRESS PRIOR TO ADMISSION				
5. DATE LEFT	FORWARDING ADDRESS				
6. REASONS FOR LEAVING FACILITY					

7. **PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, IF ANY**

NAME	ADDRESS	TELEPHONE
		( )
		( )
		( )

8. **OTHER PERSONS TO BE NOTIFIED IN EMERGENCY**

NAME	ADDRESS	TELEPHONE
a. PHYSICIAN		( )
b. MENTAL HEALTH PROVIDER, IF ANY		( )
c. DENTIST		( )
d. RELATIVE(S)		( )
e. FRIEND(S)		( )

9. **EMERGENCY HOSPITALIZATION PLAN**

NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY	ADDRESS OF HOSPITAL TO BE TAKEN IN AN EMERGENCY
MEDICAL PLAN	MEDICAL PLAN IDENTIFICATION NUMBER
NAME OF DENTAL PLAN (IF ANY)	DENTAL PLAN NUMBER (IF ANY)

10. **OTHER REQUIRED INFORMATION**

a. AMBULATORY STATUS		
b. RELIGIOUS PREFERENCE	NAME AND ADDRESS OF CLERGYMAN OR RELIGIOUS ADVISOR, IF ANY	TELEPHONE ( )

11. COMMENTS

SIGNATURE OF RESIDENT	SIGNATURE OF PERSON COMPLETING FORM	TITLE	DATE

PREPLACEMENT APPRAISAL INFORMATION

Admission - Residential Care Facilities

NOTE: *This information may be obtained from the applicant, or his/her authorized representative. (Relatives, social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).*

APPLICANT'S NAME	AGE

HEALTH (Describe overall health condition including any dietary limitations)

PHYSICAL DISABILITIES (Describe any physical limitations including vision, hearing or speech)

MENTAL CONDITION (Specify extent of any symptoms of confusion, forgetfulness: participation in social activities (i.e., active or withdrawn))

HEALTH HISTORY (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)

SOCIAL FACTORS (Describe likes and dislikes, interests and activities)

BED STATUS

☐ OUT OF BED ALL DAY ☐ IN BED ALL OR MOST OF THE TIME ☐ IN BED PART OF THE TIME	COMMENT:

TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY? ☐ YES ☐ NO	DATE OF TB TEST	☐ POSITIVE ☐ NEGATIVE
ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS? ☐ YES ☐ NO	ACTION TAKEN (IF POSITIVE)	

GIVE DETAILS

AMBULATORY STATUS (this person is ☐ ambulatory ☐ nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device. An ambulatory person must be able to do the following:

YES	NO	
☐	☐	Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
☐	☐	Mentally and physically able to follow signals and instructions for evacuation.
☐	☐	Able to use evacuation routes including stairs if necessary.
☐	☐	Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

YES	NO			
☐	☐	Active, requires no personal help of any kind - able to go up and down stairs easily		
☐	☐	Active, but has difficulty climbing or descending stairs		
☐	☐	Uses brace or crutch		
☐	☐	Feeble or slow		
☐	☐	Uses walker. If Yes, can get in and out unassisted?	☐ Yes	☐ No
☐	☐	Uses wheelchair. If Yes, can get in and out unassisted?	☐ Yes	☐ No
☐	☐	Requires grab bars in bathroom		
☐	☐	Other: (Describe)		

SERVICES NEEDED (Check items and explain)

YES	NO	
☐	☐	Help in transferring in and out of bed and dressing ______
☐	☐	Help with bathing, hair care, personal hygiene ______
☐	☐	Does client desire and is client capable of doing own personal laundry and other household tasks (specify) ______
☐	☐	Help with moving about the facility ______
☐	☐	Help with eating (need for adaptive devices or assistance from another person) ______
☐	☐	Special diet/observation of food intake ______
☐	☐	Toileting, including assistance equipment, or assistance of another person ______
☐	☐	Continence, bowel or bladder control. Are assistive devices such as a catheter required? ______
☐	☐	Help with medication ______
☐	☐	Needs special observation/night supervision (due to confusion, forgetfulness, wandering) ______
☐	☐	Help in managing own cash resources ______
☐	☐	Help in participating in activity programs ______
☐	☐	Special medical attention ______
☐	☐	Assistance in incidental health and medical care ______
☐	☐	Other "Services Needed" not identified above ______

Is there any additional information which would assist the facility in determining applicant's suitability for admission? ☐ Yes ☐ No

If Yes, please attach comments on separate sheet.

To the best of my knowledge; I (the above person) do not need skilled nursing care.

SIGNATURE	DATE COMPLETED
APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE	
SIGNATURE	DATE COMPLETED
LICENSEE OR DESIGNATED REPRESENTATIVE	DATE COMPLETED

FUNCTIONAL CAPABILITY ASSESSMENT

Licensees of Adult Residential and Social Rehabilitation Facilities must obtain the following information prior to placement. The Licensee can obtain this assessment information from the applicant or his/her authorized representative. Adult Day Care Facilities and Adult Day Support Centers may use this form to identify the functional ability of the applicant as required. The licensee must maintain this information in the client's file as a part of the Needs and Services Plan.

Note: Residential Care Facilities for the Elderly may use this form to assess the person's functional capabilities as required in Section 87584 of the regulations.

CLIENT'S NAME	DATE OF BIRTH	AGE	SEX
			☐ MALE ☐ FEMALE

Check the box that most appropriately describes clients ability:

BATHING:
- ☐ Does not bathe or shower self.
- ☐ Needs help with bathing or showering.
- ☐ Bathes or showers without help.

DRESSING:
- ☐ Does not dress self.
- ☐ Needs help with dressing.
- ☐ Dresses self completely.

TOILETING:
- ☐ Not toilet trained.
- ☐ Needs help toileting.
- ☐ Uses toilet by self.

TRANSFERRING:
- ☐ Unable to move in and out of a bed or chair.
- ☐ Needs help to transfer.
- ☐ Is able to move in and out of a bed or chair.

CONTINENCE:
- ☐ No bowel and/or bladder control.
- ☐ Some bowel and/or bladder control.
- ☐ Use of assistive devices, such as a catheter.
- ☐ Complete bowel and/or bladder control.

EATING:
- ☐ Does not feed self.
- ☐ Feeds self with help from another person.
- ☐ Feeds self completely.

GROOMING:
- ☐ Does not tend to own personal hygiene.
- ☐ Needs help with personal hygiene tasks.
- ☐ Handles own personal hygiene.

Check the box that most appropriately describes clients ability:

REPOSITIONING:
- ☐ Unable to reposition.
- ☐ Repositions from side to side.
- ☐ Repositions from front to back and back to front.

WHEELCHAIR:
- ☐ Unable to sit without support.
- ☐ Sits without support.
- ☐ Uses wheelchair.
- ☐ Needs help moving wheelchair.
- ☐ Moves wheelchair by self.

VISION:
- ☐ Severe vision problem.
- ☐ Mild/moderate vision problem.
- ☐ Wears glasses to correct vision problem.
- ☐ No vision problem.

HEARING:
- ☐ Severe hearing loss.
- ☐ Mild/moderate hearing loss.
- ☐ Wears hearing aid(s).
- ☐ No hearing loss.

COMMUNICATION:
- ☐ Does not express verbally.
- ☐ Expresses by facial expressions or gestures.
- ☐ Expresses by sounds or movements.
- ☐ Expresses self verbally.

WALKING:
- ☐ Does not walk.
- ☐ Walks with support.
- ☐ Uses walker.
- ☐ Walks well alone.

Describe client's medical history and/or conditions:

List prescription medicine:	**List non-prescription medicine:**

Describe mental and/or emotional status:

Able to follow instructions? ☐ YES ☐ NO

Confused/disoriented? ☐ YES ☐ NO

Participates in social activities? ☐ YES ☐ NO ☐ Active ☐ Withdrawn

Is there a history of behaviors resulting in harm to self or others that require supervision? ☐ YES ☐ NO
If YES, provide date____________________ and describe last occurrence:

Does he/she have ability to manage own finances and cash resources? ☐ YES ☐ NO

Is there any additional information that would assist the facility in determining client's suitability for admission? If YES, describe: ☐ YES ☐ NO

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE COMPLETED
SIGNATURE OF LICENSEE OR FACILITY REPRESENTATIVE	DATE COMPLETED