

Date of Referral: _____

Referral Agency: _____

Referral Staff: _____

Contact/Email/Fax: _____

ADMISSION APPLICATION FORM OF SHELTERED HOMES

(Sections A, B and C are to be completed by Referral Agency.)

GENERAL ADMISSION CRITERIA (Please call the Home to clarify, if necessary.)

- Client has given consent for this referral to be made.
- Age of client: 50-59 years old (subject to MCYS approval, on a case-by-case basis)
- Age of client: ≥ 60 years old
- Client is a Singapore Citizen or Permanent Resident.
- Client is ADL-independent (RAF score ≤ 15).
- Client is certified medically fit for Communal Living (e.g. those with psychiatric condition).
- Client's recent social report, medical report, RAF and Chest X-ray report are attached*.

(*Without these documents, the Home is unable to assess the client's eligibility for admission.)

SECTION A - CLIENT'S PARTICULARS & CARE STATUS (to be provided by Referral Staff)

Name (in NRIC) : _____

_____ (A.K.A.: _____)

NRIC No. : _____ (Pink / Blue)

Date of Birth (dd/mm/yyyy): _____ Age: _____

Address (in NRIC): _____

Last Known Living Arrangement

(Please tick the relevant boxes):

- Alone With spouse With parent With sibling
 With child/grandchild With relative
 With friend In Institution Others: _____

Race: Chinese Malay Indian
 Eurasian Others: _____

Gender: Male Female

Marital Status: Single Married
 Separated Divorced Widowed

Preferred Language/Dialect:

- English Mandarin Malay
 Tamil Cantonese Hokkien
 Teochew Hainanese
 Others: _____

Religion: Buddhism Taoism
 Christianity Catholicism Islam
 Hinduism Others: _____

Reason(s) that placement to Sheltered Home is client's preferred option

(Please tick the relevant boxes)

- Client's rental flat was repossessed by HDB.
 Client sold his/her only flat away, and is unable to buy another flat.
 Client is placed under HDB's waiting list for rental flat.
 All the family members of client (e.g. children) refuse to provide accommodation.
 Client refuses to live with his/ her family member, although this option is available.
 Client has behavioural or physical issues, which are beyond the carer's ability to cope.
 Client is unable to self-maintain and is deemed not suitable to live alone.
 Client was under abuse or neglect by family member(s).
 Client has exhausted his/ her savings.
 Client has exhausted social resources to cope with independent living (deemed by Referral Agency).
 None of the above. (To elaborate in social report; Brief reason: _____)

Next-of-Kin/Guarantor# will attend interview with client: Yes No

Next-of-Kin/Guarantor# will support client financially for the stay in this Home: Yes No

Name of NOK/ Guarantor: _____

NRIC : _____ (Pink / Blue)

Relationship with client: _____ Age: _____

Contact numbers : _____ (HP) _____ (O)

Current address : _____

Brief note on this NOK/ Guarantor:

Note: St John's Home For Elderly Persons requires **TWO** sponsors/ guarantors. Please reflect this in Genogram. If client is on P.A., please verify with the Home if it is possible for guarantor to be a non-familial person.

SECTION B – SOCIAL REPORT (to be provided by Referral Staff)

List of Required documents (please tick if applicable and document is attached):

- Copy of NRIC (Client) Copy of NRIC (NOK/Guarantor) CPF statement (Client)
- Copy of P.A. Card Copy of LPA Copy of MFEC Bank statement
- NOK/Guarantor’s proof of monthly income (may require self-declaration for means-testing)
- Copy of Means-Test Declaration Form

Genogram (to reflect Client’s last-known living arrangement)

Age	Names of Family Members & Guarantors	Relationship with Client	Contact	Monthly Income	Occupation

Description of Client’s Relationship with Family:

Client’s Means of Subsistence:

(Please tick the relevant boxes)

- Work: \$ _____ (per day) or \$ _____ (per month); Type of Work: _____
- Personal Savings : \$ _____ (total estimate)
- Insurance / Annuity Payout : \$ _____ (per month)
- Support from Friend / Family Member / Relative* : \$ _____ (per day) or \$ _____ (per month)
- Claim maintenance via the Tribunal (pending/finalised/defaulted*): \$ _____ (per month)
- Public Assistance Scheme (PA Card no. _____)
- Welfare grant (CDC) : \$ _____ (per month) for _____ months
- Social Service Agency : \$ _____ (per month) for _____ months
- Religious organisations : \$ _____ (per month) for _____ months

*Please delete as appropriate.

Additional notes on family’s situation (e.g. financial): _____

All the information provided in Sections A and B is true and accurate.	Verified by:	Witnessed by:
	_____ NOK / Guarantor or Client	_____ Name of Staff: _____ Date: _____

SECTION C – MEDICAL REPORT (to be endorsed / signed by a Medical Doctor)

Client's medical report, RAF, and Chest X-ray report should be attached to this application. Without these documents, the Home *is unable to assess* the client's eligibility for admission.

Name of Patient: _____ NRIC: _____

Primary Diagnosis & Clinical Findings:**Other Significant Medical History/ Secondary Diagnosis:**

Diabetes Mellitus Hypertension High Blood Pressure HIV CVA/Stroke IHD
 MRSA colonised/infective Tuberculosis Dementia (Please attach Psychiatrist's report)

Others (e.g. psychiatric conditions, skin conditions), please specify: _____

Is patient suffering from any infectious disease? No Yes, if specify: _____

Psychological & Behavioural Condition (please tick the relevant boxes for **ALL** listed items):

Agitation &/or Aggression : N.A. Occasionally Frequent Always
 Violence : N.A. May self-inflict Verbally Abusive Physically Abusive Has suicidal ideation
 Bed Restraint : N.A. Required temporarily Required occasionally Required permanently
 Sleep / Disruption: Able to sleep Relies on sleeping pills Required sedation Chronic sleep issues

Summary of Nursing & Rehab Needs (please tick the relevant boxes for **ALL** listed items):

Feeding & Dietary : N.A. Special diet Ryle's tube PEG Flexiflo
 Respiratory & Cardiovascular : N.A. O2 Therapy BiPAP Machine
 Stoma / Gastro-intestinal : N.A. Colostomy Tracheotomy Care Ileostomy
 Urinary Tract : N.A. Intermittent Cath. Supra-pubic Cath. Urethra
 Kidney / Renal : N.A. Kidney/Renal Care (with medication) Hemodialysis
 Wound Care : N.A. Prone to bedsores Minor/infrequent Intensive/frequent
 Client has impairment(s) which affect verbal communication: N.A. Sight Speech Hearing
 Doctor's report on chest X-Ray: _____
 Other medical condition, please specify: _____
 Client is certified to be fit for light exercise : Yes No
 Client is certified to be fit for communal living : Yes No
 Client is recommended for Physical Medicine & Rehabilitation (PM&R)[#] : Yes No

[#]Previous rehabilitation/treatment plan by PT or OT needs to be furnished for reference.

List of Current Medications*:

Any drug allergy / other allergy: No Yes, please specify:

1.	5.
2.	6.
3.	7.
4.	8.

*Please attach photocopies of patient's appointment cards to ensure medical appointments are tracked.

Endorsed/ Signed by : _____ Date: _____
 Name of Doctor (Dr) : _____
 Designation/Dept/Institution : _____

FOR USE BY SHELTERED HOMES ONLY

SECTION D – RESPONSE SLIP (Home Staff to email/fax to Referral Staff within 5 working days from the date when referral was received)

Date : _____
Fax / Email of Referral Officer : _____
Name of Referral Staff : _____
Designation/Dept/Institution : _____

Intermediate Outcome of Application:

- Client is eligible for admission to my Sheltered Home at this stage (*application form is complete, recommended for interview & final approval*)
- Client is unsuitable for admission (*application is rejected, please note reasons below*)
- Application form is incomplete, please refurnish information for Section A / B / C*.
- Missing document(s) to be furnished: _____

**Please circle accordingly*

Signed by (Home Staff) : _____ Date: _____
Name of Home Staff : _____
Designation / Agency : _____
Contact / Email / Fax : _____

SECTION E – OUTCOME OF REFERRAL (Home Staff to email/fax to Referral Staff within 10 working days from the date when Section D was emailed/faxed to Referral Agency)

Final Decision of Admission Committee: Rejected¹ Pending² Approved³
Fee Payable (monthly) : \$ _____ / FOC (*please delete accordingly*)
Date / Time of Meeting : _____
Signature by Approving Officer : _____
Name of Approving Officer : _____
Reasons (for rejected application) : _____

¹The Home Staff can reject the application based solely on the information provided in the admission form and documents at the intermediate stage of application. Rejected application will not be processed by the Admission Committee. The Home Staff shall refer these applicants to alternative options.

²If the case is pending approval, please update the Referral Staff (email/fax/call) regarding this status and inform them about the date of meeting by the Admission Committee.

³After an approval is given, NOK/ Guarantor(s) is/ are required by the Home to sign a declaration form (Undertaking for Admission). The Referral Staff shall educate NOK/ Guarantor(s) about this procedure and their obligations. The approval status may be affected if they fail to sign this form. This form can be obtained from respective Homes.

Client has passed the means test : N.A. Yes No
Client will enjoy subsidies (*if applicable*) at: MCYS[#] 75%/ 60%/ 50%/ 40%/ 20% (SC)
MCYS[#] 50%/ 40%/ 30%/ 20%/ 0% (PR)
NCSS 10% (SC & PR)

[#]The Sheltered Homes with MCYS funding are AWWA Community Home for Senior Citizens, PERTAPIS Senior Citizen Fellowship Home, Evergreen Place Home@Hong San and Geylang East Home for the Aged.

IMPORTANT NOTE: This Admission Application Form is developed by the National Council of Social Service, in consultation with the Sheltered Homes and MCYS. Please contact NCSS for any further enquiry.

Resident Assessment Form (For Nursing Home Resident)

[to be completed by nurse, nurse case manager or doctor]

Name:		NRIC No:			
Rating	A	B	C	D	
Q1 Mobility (Guide Bk Pg1)	Independent <div style="text-align: right;">0</div>	Requires some Assistance (physical/assistive device) <div style="text-align: right;">3</div>	Requires frequent assistance/ turning in bed <div style="text-align: right;">10</div>	Requires total physical assistance <div style="text-align: right;">16</div>	
Q2 Feeding (Guide Bk Pg 2)	Independent <div style="text-align: right;">0</div>	Requires some Assistance <div style="text-align: right;">3</div>	Requires total Assistance <div style="text-align: right;">10</div>	Tube-feeding <div style="text-align: right;">10</div>	
Q3 Toileting (Guide Bk Pg 3)	Independent <div style="text-align: right;">0</div>	Requires some physical assistance <div style="text-align: right;">3</div>	Requires commodes / bedpans / urinals <div style="text-align: right;">8</div>	Incontinent and totally dependent <div style="text-align: right;">16</div>	
Q4 Personal Grooming & Hygiene (Guide Bk Pg 4)	Requires no assistance <div style="text-align: right;">0</div>	Requires assistance for some activities/ supervision <div style="text-align: right;">2</div>	Requires assistance for all activities <div style="text-align: right;">4</div>	Bed/ trolley bathing <div style="text-align: right;">6</div>	
Q5 Treatment (Guide Bk 6-6)	Daily Medication Oral/Topical : 1 pt <div style="text-align: right;">0</div>	Daily Medication Oral/Topical : 1 pt Injection: 2 pts <div style="text-align: right;">0</div>	Daily Medication Oral/Topical : 1 pt Injection: 2 pts Physiotherapy:4 pts <div style="text-align: right;">0</div>	Daily Medication Oral/Topical : 1 pt Injection: 2 pts Physiotherapy:4 pts Sp*procedures @1 pt/ 5 min <div style="text-align: right;">0</div>	
Q6 Social & Emotional Needs (Guide Bk pg 7)	Nil <div style="text-align: right;">0</div>	Occasionally <div style="text-align: right;">1</div>	Often <div style="text-align: right;">2</div>	Always <div style="text-align: right;">3</div>	
Q7 Confusion (Guide Bk Pg 8-9) ▪ loses way ▪ loses things ▪ disorientated	Nil <div style="text-align: right;">0</div>	Occasionally (1-3 times a week) <div style="text-align: right;">3</div>	Often (4-6 times a week) <div style="text-align: right;">8</div>	Always (Daily) <div style="text-align: right;">10</div>	
Q8 Psychiatric Problems (Guide Bk 10-11) ▪ hallucination ▪ delusions ▪ anxiety ▪ depression	Nil <div style="text-align: right;">0</div>	Mild Interference in Life <div style="text-align: right;">2</div>	Moderate Interference in Life <div style="text-align: right;">4</div>	Severe Interference in Life <div style="text-align: right;">6</div>	
Q9 Behaviour Problem (Guide Bk pg 12-13) ▪ restless ▪ disruptive ▪ absconds ▪ uncooperative	Nil <div style="text-align: right;">0</div>	Occasionally (1-3 times a week) <div style="text-align: right;">3</div>	Often (4-6 times a week) <div style="text-align: right;">10</div>	Always (Daily) <div style="text-align: right;">16</div>	
Total Points	Category 1 2 3 4 (Circle)				

* Sp – Special #Pt – Points

Category 1	<6 pts	Category 2	7 – 24 pts
Category 3	25 – 48 pts	Category 4	>48 pts

Name of Officer Completing RAF : _____ / NRIC/FIN number: _____

Designation/Institution _____ / _____

Date _____