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 the full monthly amount of $1400 per month. 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.
8. Copy of birth certificate.
9. Copy of Proof of Income.

ALL HIGHLIGHTED areas require appropriate signatures.
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: _____

Date of Birth: _____

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 Approximate Dates: _____

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: _____ DOB: _____

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 need placement_____

_____

_____

_____

_____

_____

What are your goals? _____

_____

_____

_____

_____

_____

_____

Completed by: _____ Date: _____

The Stewart Community Home, Inc.
APPLICATION FOR ADMISSION

MEDICAL INFORMATION

Name of Applicant: _____ DOB: _____

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: _____

The Stewart Community Home, Inc.
APPLICATION FOR ADMISSION

PLACEMENT HISTORY

Name of Applicant: _____ DOB: _____

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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Name of Applicant: _____ DOB: _____

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: _____

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

Applicant Name: _____ DOB: _____

The Stewart Community Home, Inc.
Vitals and 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

Page 2

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: _____
_____
_____
_____

As a part of daily resident care and evaluation, resident will have vitals checked daily that will include O2 sat, blood pressure, and temperature.

Physician Signature: _____ Date: _____

Physician Name (Printed): _____

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Authorization for Release of Information

Name of Resident at time of care: _____

Date of Birth: _____ Approximate dates of care and treatment: _____

Disclosure is necessary for the purpose of: _____, and that person only. I understand this authorization extends to all or any part of the records/information designated below, which may include treatment for the physical and mental illness, alcohol/drug abuse, HIV/AIDS testing and results or diagnoses. This information to be released includes:

___ History and Physical	___ Evaluation	___ Progress Note Summary
___ Discharge Summary Plan	___ Discharge Summary	___ Intake Assessment
___ Treatment plan and Updates	___ Abstract Summary	___ Medication Information
___ Other _____		

I hereby authorize:
Person or Facility: _____

Address: _____ Phone: _____

This information is to be released to (Person or Facility): _____

Address: _____ Phone: _____

_____ I authorize the source named above to speak by telephone or in person with _____ about reasons from the referral, any relevant history or diagnoses, and other similar information that can assist with receiving treatment or being evaluated or referred elsewhere.

The treatment dates covered by this authorization are from the pre-admission to discharge and claims resolution. In any event, I may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. I hereby release Stewart Community Home, Inc. from all legal responsibilities or liability that may arise from disclosure or medical records in reliance to the Authorization.

I/He/She understand(s) that the nature of the release and freely give(s) my consent:

Resident Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

REVOCATION: I have the right to stop this release of information at any time. I understand that I cannot do anything about information that has already been disclosed under this authorization. Revocation of this release must be submitted in writing, signed, dated, and handed directly to the Executive Director or Facility Nurse.

STEWART COMMUNITY HOME
ADMISSIONS AGREEMENT

The management of this Personal Care Home, the Stewart Community Home, Inc. (SCH), which is located at 1125 15th Street Columbus, Ga 31901, hereby agrees to assume 24-hour watchful oversight for the undersigned resident. Protective care and watchful oversight services provided will include, but will not necessarily be limited to, a daily awareness by management of the resident's functioning and condition; supervision of personal care and Adult Daily Living Skills (ADLS); the scheduling of and reminders of medical appointments; the ability and readiness to intervene if a crisis arises for the resident, including calling emergency transportation; supervision in areas of nutrition and medication maintenance/self-administration; the initial acquisition and refilling of prescribed medications (to be paid for by resident or resources acquired on their behalf); and actual provision of transportation to scheduled medical and other appointments of the resident if not provided by any other agency.

Management acknowledges that the above provisions include 24-hour a day lodging; 3 balanced meals per day and 2 nutritious snacks per day; provision of laundry facilities in the home; bedding supplies (sheets, pillowcases and covers); clothing, towels, soap, toilet tissue, and light bulbs; continuous assessments of each resident's needs and condition; and informing sponsors or guardians of any changes in the resident's condition that may warrant transfer, discharge, or concern.

Management further agrees to provide the resident with a 30-day written notice prior to discharge or transfer and to provide a 30-day notice prior to a change in the fees charged for the services identified in this agreement. Any resident may discharge himself/herself by giving a written notice. Management will assist in arranging for appropriate transfer and/or referral when needed/appropriate and possible; however, the ultimate responsibility remains with the resident and/or their family member or outside case manager.

A resident **may** be considered for immediate discharge/transfer for (but not limited to) the following circumstances:

- A positive drug screen.
- A positive alcohol screen related to inappropriate or self-injurious behaviors.
- The resident's condition becomes such that skilled nursing or more intense oversight/care is immediately required. (If a resident is determined by medical personnel to have a deteriorating mental or physical health condition, the Stewart Community Home will begin processes to assist the resident and/or their family members in finding alternative placement for the resident.)
- A resident who is violent and combative to other residents and /or staff.
- A resident who is jailed by law enforcement officers.
- A resident who is caught stealing or destroying personal or Stewart Community Home Property
- A resident who is caught sharing medications with anyone.
- A resident found to be in possession of any type of weapon, including pocketknives.
- A resident who smokes inside the building or in areas where smoking is not allowed and/or continuously drops cigarette butts and smoking paraphernalia around the facility and not in appropriate trash receptacles.

The circumstances for immediate discharge/transfer have been explained to me and I understand them completely.

Initials_____

STEWART COMMUNITY HOME

Fee Agreement/Refund Policy

The monthly charge for services identified in this agreement is:

RESIDENT MONTHLY INCOME: _____ _____ Initials

FEE FOR SERVICES: _____

Due to our commitment to serve individuals regardless of their ability to pay, our residents are charged a fee for services based solely on the amounts provided from their proof of income. Management and residents will sign a new "Fee for Service" agreement each year, which will reflect the amount charged based on the resident's total income. Residents will provide Stewart Home a copy of their proof of income upon admission **and** once per year thereafter.

The daily fee for services provided at the Stewart Community Home is $46.05 a day or $1400.00 per month.

Upon admission, residents will sign a payee agreement making either the Stewart Home or third-party services the payee for any SSI/SSDI income. Those residents whose income enables them to pay the $1400.00 per month will be charged that amount. Income exceeding that amount will be placed in a personal spending account for them or will be maintained by their payee/guardian. Money placed in the residents' personal spending account will be distributed to them on a weekly basis, divided equally, or otherwise, as outlined in their individual service plan/personal treatment plan. Residents whose income does not allow them to pay the entire $1400.00 per month will be charged according to and including their total income.

Each year, individuals receiving social security or SSI may receive entitlement increases. The actual cost of services will remain the same for residency at SCH, $46.05 a day or $1400.00 a month. Therefore, each increase a resident receives in income will increase their fee for service until their income level reaches $1400.00 per month.

Residents who pay rent will receive $15.00 per week for personal spending. Residents will not be required to perform any work or services for this weekly amount.

Residents who receive SSI/SSDI or VA approval and monies during their stay at Stewart Community Home will be responsible for prorated balances due for prior months of residency at the Stewart Community Home. In other words, any monies paid retroactively from the time of application to approval will be owed to Stewart Home for prior months of services based on their monthly income.

Residents who have bills that must be paid out of SSI/SSDI or VA income must have those bills approved by the Executive Director prior to admissions and MUST provide copies of invoices or statements before approval can be given.

Residents receiving in-patient care may have their bed held for up to 30 days with the approval of the Admissions Director and Executive Director.

Initials_____

When a resident transfers, is discharged prior to the appropriate 30-day notice, discharges himself/herself with or without notice, dies, or is discharged on an emergency basis, a refund is due only if the prorated amount of fees is less than the resident's total income for that 30-day period. Full-pay resident refunds will be prorated on the daily rate of the resident's fees.

Initials_____

Residents who are jailed by virtue of conviction and sentencing will not be permitted to have their bed held for any reason. Residents who are jailed for charges and not yet convicted, can have their bed held for thirty (30) days only.

Residents with documented Substance Abuse issues, who are discharged or transferred for substance abuse related circumstances, must complete a substance abuse program before being considered for readmission.

Residents or responsible parties are financially responsible for all costs incurred for medical, dental, medication and hospitalization costs. Residents or responsible parties are responsible for all costs related to and for ambulance services.

Residents may not keep medications in their possession unless they are signing them out for a home visit or a physician's order permits it (Examples: Inhalers, diabetes supplies, Epi-pen, etc.).

Residents may only have visitors in the family room or outside and are never to take visitors into other rooms unless approved by the Operations Director or Executive Director.

Residents who are determined to be in need of emergency services who then refuse to be transported by ambulance to the hospital will be responsible for the associated costs and/or fines.

Initials_____

This policy/document has been fully explained to applicant and /or his /her sponsor/guardian, and a copy has been provided to them.

This document also serves as a medical information release authorization and recognition of the attached release of information form.

I understand this document and have been provided with a copy of it.

Resident/Responsible Party

_____ _____

Signature Date

Community Case Manager (if applicable)

_____ _____

Printed Name Date

SCH Staff

_____ _____

Printed Name Date

10.20.2023