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: _____________________ NOK / Guarantor or Client	Witnessed by: ________________________ 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 ☐ Illeostomy
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: ☐ Rejected[1] ☐ Pending[2] ☐ Approved[3]

Fee Payable (monthly) : $________________ / FOC *(please delete accordingly)*

Date / Time of Meeting : ________________

Signature by Approving Officer : ________________

Name of Approving Officer : __________________________________

Reasons (for rejected application) : __________________________________

____

____

[1]*The 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.*

[2]*If 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.*

[3]*After 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 0	Requires some Assistance (physical/assistive device 3	Requires frequent assistance/ turning in bed 10	Requires total physical assistance 16
Q2 Feeding (Guide Bk Pg 2)	Independent 0	Requires some Assistance 3	Requires total Assistance 10	Tube-feeding 10
Q3 Toileting (Guide Bk Pg 3)	Independent 0	Requires some physical assistance 3	Requires commodes / bedpans / urinals 8	Incontinent and totally dependent 16
Q4 Personal Grooming & Hygiene (Guide Bk Pg 4)	Requires no assistance 0	Requires assistance for some activities/ supervision 2	Requires assistance for all activities 4	Bed/ trolley bathing 6
Q5 Treatment (Guide Bk 5-6)	Daily Medication Oral/Topical : 1 pt	Daily Medication Oral/Topical : 1 pt Injection: 2 pts	Daily Medication Oral/Topical : 1 pt Injection: 2 pts Physiotherapy:4 pts	Daily Medication Oral/Topical : 1 pt Injection: 2 pts Physiotherapy:4 pts Sp*procedures @1 pt/ 5 min
Q6 Social & Emotional Needs (Guide Bk pg 7)	Nil 0	Occasionally 1	Often 2	Always 3
Q7 Confusion (Guide Bk Pg 8-9) ▪ loses way ▪ loses things ▪ disorientated	Nil 0	Occasionally (1-3 times a week) 3	Often (4-6 times a week) 8	Always (Daily) 10
Q8 Psychiatric Problems (Guide Bk 10-11) ▪ hallucination ▪ delusions ▪ anxiety ▪ depression	Nil 0	Mild Interference in Life 2	Moderate Interference in Life 4	Severe Interference in Life 6
Q9 Behaviour Problem (Guide Bk pg 12-13) ▪ restless ▪ disruptive ▪ absconds ▪ uncooperative	Nil 0	Occasionally (1-3 times a week) 3	Often (4-6 times a week) 10	Always (Daily) 16
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 ____________