230 Washington Way
Centralia, WA 98531
360-736-9178
www.popesplace.org
Fax: 360-736-8312

Resident Application Form

Personal Information

Resident Legal Name: Preferred Name/Nickname: Pronouns: SSN:
DOB: Age: Admission Date: Projected/Actual Discharge Date:

Guardian/Responsible Party Name: Relationship to Resident:
Address: Phone Number: Email:

Demographics

Race/Ethnicity (select all that apply):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White/Caucasian
- ☐ Other:

Religious/Cultural Preference (for care planning and accommodations):
- ☐ Buddhist
- ☐ Christian
- ☐ Catholic
- ☐ Islam
- ☐ Judaism
- ☐ No Religion
- ☐ Other:

Sexual Orientation, Gender Identity, and Expression (SOGIE)

Collected to support respectful, affirming care.

Sex Assigned at Birth:
- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Other:
- ☐ Declines to state

Gender Identity:
- ☐ Female
- ☐ Male
- ☐ Nonbinary
- ☐ Transgender
- ☐ Other:
- ☐ Declines to state

Gender Expression:
- ☐ Feminine
- ☐ Masculine
- ☐ Androgynous
- ☐ Varies / Fluid
- ☐ Other:
- ☐ Declines to state

Language & Communication

Primary Language:
Secondary Language(s):
Interpreter Needed: ☐ Yes ☐ No

Preferred Communication Method:
- ☐ Verbal
- ☐ AAC / Device
- ☐ Gestures / Visuals
- ☐ Written
- ☐ Other:

Programs & Services

Program:
- ☐ Residential
- ☐ Transitional
- ☐ Respite

Home:
- ☐ Vivian's House Adult Family Home/Adult Respite Home
- ☐ Eagle's House Pediatric Group Home
- ☐ Jim's House Pediatric Respite Home

Means of Payment:
- ☐ Insurance
- ☐ DDA Waiver Services
- ☐ Private Pay
- ☐ DDA Enhanced Respite Services (ERS)
- ☐ Other:

Placement Status:	Third Party Payee:	Income:
☐ State Placement/State Custody ☐ Voluntary Placement/Parental/Guardian Custody ☐ Paid Guardianship/Placement	☐ Reliable Enterprises ☐ Share & Care ☐ Other:	☐ SSDI ☐ Allowance ☐ Other:

Insurance

Insurance Company: Group/ID Number: ProviderOne Number:
☐ State Insurance ☐ Private Insurance

Behavioral Considerations, Supports and Interventions

Self-injurious behaviors (e.g., head-banging, biting, scratching) ☐ Yes ☐ No
Aggression toward others (e.g., hitting, kicking, biting, pinching) ☐ Yes ☐ No
Verbal aggression (e.g., yelling, screaming, threats) ☐ Yes ☐ No
Property destruction (e.g., breaking items, throwing objects) ☐ Yes ☐ No
Elopement or attempts to leave supervised areas ☐ Yes ☐ No
Difficulty with transitions or changes in routine ☐ Yes ☐ No
Sensory sensitivities (e.g., sound, light, textures) ☐ Yes ☐ No
Anxiety or panic attacks ☐ Yes ☐ No
Repetitive behaviors or stimming ☐ Yes ☐ No
Sexualized behaviors ☐ Yes ☐ No
Current behavior support plan (attach if available) ☐ Yes ☐ No

Activities, Community Integration, and Inclusion

Can the applicant read? ☐ Yes ☐ No If yes, what type of material do they like to read?
Are there any activities or skills the applicant would like to work on?
Are there any particular religious or cultural considerations we should be aware of?
What types of activities is the applicant interested in?
What types of activities does the applicant not enjoy?
What types of community outings is the applicant interested in?
What types of community outings does the applicant not enjoy?

Goals

Clinical
Social/Behavioral
Physical Therapy
Education
Appointments
Financial
Other

Direct Services

Is the applicant currently enrolled in Birth-3/Early Intervention Services? ☐ Yes ☐ No
Is the applicant currently enrolled in school? ☐ Yes ☐ No If yes, what school district: Grade:
Is the applicant currently on palliative care services? ☐ Yes ☐ No
Is the applicant currently using hospice care services? ☐ Yes ☐ No
Respite ONLY: Would you like the applicant to have PT services during their stay? ☐Yes ☐No
Currently receiving therapies? (e.g., ABA, OT, PT, Speech) ☐ Yes ☐ No If yes, what?

Diagnoses and Past Medical History

Applicant's primary diagnosis (including approximate date of diagnosis):
All other applicant's secondary diagnoses (including approximate date of diagnosis):
Applicant's past medical history (procedures and/or surgeries):
Code Status: POLST ☐ Yes ☐ No
Was the applicant a premature infant? ☐ Yes ☐ No If yes, how premature?

Does the applicant have a brain injury or deficit? ☐ Yes ☐ No If yes, please describe:
Does the applicant receive dialysis? ☐ Yes ☐ No
Does the applicant receive infusions? ☐ Yes ☐ No

Family and Care Team						
Role	Specifics	Name	Phone	Full Address	Email	Fax
Responsible Parties ** - legal guardian	Parent					
	Caseworker					
	Certified Professional					
	Power of Attorney					
	Other:					
Caseworker	DCYF/CPS					
	DDA					
	DDA NCC					
	DSHS HCS					
	Tribal					
	Other:					
Pharmacy	Primary:					
	Secondary:					
Providers	Primary Care Last seen:					
	Pulmonologist Last seen:					
	Otolaryngologist Last seen:					
	Gastroenterologist Last seen:					
	Nutritionist/Dietician Last seen:					
	Audiologist Last seen:					
	Orthopedist Last seen:					
	Physical Therapist Last seen:					
	Ophthalmologist Last seen:					
	Hospice Last seen:					
	Palliative Care Last seen:					
	Physiatrist Last seen:					
	Neurologist Last seen:					
	Speech Language Pathologist					

	Last seen:					
	Occupational Therapist Last seen:					
	Cardiologist Last seen:					
	Endocrinologist Last seen:					
	Urologist Last seen:					
	Nephrologist Last seen:					
	Podiatrist Last seen:					
	Infectious Disease Last seen:					
	Dentist Last seen:					
	Alternative Physician Last seen:					
	Other: Last seen:					

Invasive Risk Factors
☐ Trach - Type: Size: Balloon fill: Back up size: ☐ G-tube ☐ J-tube ☐ G/J-tube - Type: Size: Balloon fill: Back up size: Please list type and size for any item below: ☐ Central Line ☐ PICC Line ☐ Port ☐ Ostomy ☐ S/P Cath ☐ Foley ☐ Mitrofanoff ☐ Other:

Immunization History

Residents are required to follow immunization schedules as recommended by the WA Department of Health and the resident's primary care provider (PCP), with medical exemptions, delays, or alternative schedules permitted when clinically indicated and ordered by the provider.

Immunization	Date(s) Received
Hepatitis B (HepB)	
Rotavirus (RV)	
Diphtheria, Tetanus, and Pertussis	
Haemophilus influenzae type b (Hib)	
Pneumococcal Conjugate (PCV15 or PCV20)	
Inactivated Poliovirus (IPV)	
Measles, Mumps, and Rubella (MMR)	
Varicella (Chickenpox)	
Hepatitis A (HepA)	
Human Papillomavirus (HPV)	
Influenza (annual)	
Meningococcal Conjugate (MenACWY)	
Meningococcal B (MenB)	
COVID-19	
Respiratory Syncytial Virus prevention (RSV monoclonal antibody or maternal vaccine–related protection)	

Health Monitoring

Monitor	Baseline	Notes
☐ Oxygen Saturation	%	
☐ Oxygen Use	L	
☐ Pain		
☐ Weight Loss/Gain	Lbs.	
☐ Vital Signs		
☐ Blood Glucose		
☐ Temperature		
☐ Spasticity		

Seizure Information

Does the applicant have a seizure disorder? ☐ Yes ☐ No If yes, please describe:
Seizure rescue protocol (including rescue medication):
Typical seizure presentation and duration:

Medications

Please provide a list of medication names, purposes, dosages, and frequency and time of administration.
You must include all over the counter and (PRN) as needed medications.
How is medication administered to the applicant?
Type of Medication Administration:
☐ Oral ☐ Topical ☐ Intra-aural ☐ Ophthalmic ☐ Inhalation ☐ Intra-nasal ☐ Injections (SQ/ID/IM/IV)
☐ Rectal ☐ Enteral ☐ Other:

Allergies: Please write *allergy, sensitivity,* OR *intolerance* in each section below to indicate the significance level.

Medication	Allergy, sensitivity, or intolerance	Reaction
Environmental	Allergy, sensitivity, or intolerance	Reaction
Food	Allergy, sensitivity, or intolerance	Reaction

Multidrug-Resistant Organisms (MDROs) and Precautions

Does the applicant have any known infections or colonizations (MDROs)? ☐ Yes ☐ No If yes, what are they?
Are there any special precautions? ☐ Enhanced Barrier Precautions ☐ Droplet Precautions ☐ Other:

Supplies and Equipment

Equipment/Devices Used	Mobility		
	Communication		
	Respiratory	(If vent, CPAP/BIPAP/O2, please include settings)	
	Enteral Feeding		
	Elimination		
	Other:		
Supply and DME Companies	Company	Provides	Phone Number
	Other:		

Typical Routine	
Morning	0500-0600:
	0600-0700:
	0700-0800:
	0800-0900:
	0900-1000:
	1000-1100:
	1100-1200:
Afternoon	1200-1300:
	1300-1400:
	1400-1500:
	1500-1600:
	1600-1700:
Evening	1700-1800:
	1800-1900:
	1900-2000:
	2000-2100:
	2100-2200:
Night	2200-2300:
	2300-0000:
	0000-0100:
	0100-0200:
	0200-0300:
	0300-0400:
	0400-0500:
Bedtime Routine	Describe any unique bedtime routines:
Sleeping	What type of bed does the applicant sleep in? Are side rails or other safeguards used to prevent falling out of bed? ☐ Yes ☐ No Does the applicant require a unique positioning for sleeping? ☐ Yes ☐ No Does the applicant take any particular item to bed? (blanket, toy, unique stuffed animal, etc.): ☐ Yes ☐ No What are the applicant's regular sleeping habits? (Wake up during the night, etc.? If so, are interventions used so the applicant will return to sleep?):

Activities of Daily Living (ADLs)
Mobility (Inside and Outside the Home)
Can the applicant sit up? ☐ Yes ☐ No Can the applicant stand? ☐ Yes ☐ No Can the applicant walk? ☐ Yes ☐ No Do the applicant's physical limitations require any DME for mobility? ☐ Yes ☐ No If yes, what kind/type of DME: Does the applicant wear orthotics/splints? ☐ Yes ☐ No If yes, what is their typical schedule?

What level of assistance is needed for applicant mobility?
How many falls has the applicant had in the last year?
What kind of bed does the applicant sleep in? Will the bed be coming with them?

Dressing

Can the applicant dress themselves? ☐ Yes ☐ No
Applicant clothing and shoe sizes:
Applicant clothing preference(s):
Level of assistance needed for applicant dressing? Fully Dependent

Showering, Bathing, and Personal Hygiene

Can the applicant brush their teeth? ☐ Yes ☐ No
Does the applicant use deodorant? ☐ Yes ☐ No
Applicant's shower/bath schedule preference:
Applicant's skincare routine:
What assistance is needed for the applicant's showering, bathing, and personal hygiene?
What equipment is needed for bathing routine (shower chair)? Fully Dependent

Communication and Tools

Does the applicant speak? ☐ Yes ☐ No
Does the applicant require any hearing assistive devices? ☐ Yes ☐ No
Does the applicant use non-verbal cues? ☐ Yes ☐ No If yes, what are they?
Do those outside the family understand the applicant's speech? ☐ Yes ☐ No
What other methods of communication does the applicant use?
What level of assistance and tools is needed for applicant communication? Fully Dependent

Toileting and Continence

Is the applicant toilet-trained? ☐ Yes ☐ No
Does the applicant wear diapers or briefs? ☐ Yes ☐ No If yes, what size?
Does the applicant menstruate? ☐ Yes ☐ No If yes, how often?
Do the applicant's physical limitations require any DME for toileting and continence? ☐ Yes ☐ No If yes, what kind/type of DME:
Does the applicant have trouble with constipation? ☐ Yes ☐ No
Does the applicant have any current or chronic skin concerns?
Does the applicant have any current or historic pressure sores? If yes, where:
What level of assistance is needed for applicant toileting and continence? Fully Dependent

Managing Finances, Shopping, and Transportation

Can the applicant manage money? ☐ Yes ☐ No
What level of assistance is needed for applicant finance management? Fully Dependent

Shopping

Is the applicant able to shop? ☐ Yes ☐ No
What level of assistance is needed for applicant shopping? Fully Dependent

Transportation

Will anyone be transporting the applicant to appointments besides Pope's Place? ☐ Yes ☐ No
If yes, who and what is their relationship to the applicant:
What level of assistance is needed for applicant transportation? Fully Dependent

Bed Mobility and Transfers

How would you describe the applicant's bed mobility? ☐ Good ☐ Fair ☐ Poor
Do the applicant's physical limitations require any DME for bed mobility and transfers? ☐ Yes ☐ No
If yes, what kind/type of DME?
What level of assistance is needed for applicant bed mobility and transfers? Fully Dependent

Eating, Drinking, and Nutrition

Is the applicant NPO (nothing by mouth) ☐Yes ☐No
If no, what kind/type of diet?
Explain the applicant's unique feeding methods (does their food need to be blended, pureed, or cut up into small pieces, etc.?):
Applicant's favorite foods: Applicant's least favorite foods:
Is the applicant able to feed themselves? ☐ Yes ☐ No
Is the applicant right or left-handed?
Do the applicant's physical limitations require unique adaptive eating, drinking, and nutrition tools? ☐Yes ☐No
If yes, what kind/type of adaptive tools?
Does the applicant like/want snacks throughout the day?
What assistance is needed for the applicant's eating, drinking, and nutrition?
To your knowledge, does the applicant require one-to-one care for feeding ?
If enteral fed: What is the applicant's formula name? What is the recipe/mixture instructions and total volume?
Does the applicant use a feeding pump? ☐ Yes ☐ No If yes, bolus or continuous? ☐ Bolus ☐Continuous
What rate? Dose per feed? If not continuous, number of feeds per day?
Does the applicant use push bolus feed? ☐ Yes ☐ No If yes, what amount?
How many feeds per day?
Does the applicant use gravity feeds? If yes, what amount?
How many feeds per day? Run: ☐ Slow ☐Medium ☐ Fast
What is the applicant's tube feed schedule (time on/off, etc.)?
Does the applicant get free water? ☐ Yes ☐ No If yes, what amount?
Does the applicant get water flushes after feeds and medciations? ☐Yes ☐No If yes, what amount?

Safety Awareness and Risks

Lacks awareness of danger (e.g., running into the street, touching hot surfaces) ☐Yes ☐No
Non-verbal or limited communication ☐Yes ☐No
Requires constant supervision due to mobility or behavioral needs ☐Yes ☐No
Mobile but no safety awareness (e.g., climbing, wandering) ☐Yes ☐No
History of elopement from home, school, or community ☐Yes ☐No
Requires supervision or assistance with:
- Kitchen appliances (e.g., stove, oven) ☐Yes ☐No
- Bathroom safety (e.g., hot water, slipping risk) ☐Yes ☐No
- Stairs or uneven surfaces ☐Yes ☐No

Additional Information

Is there anything else you would like us to know?