

# Pre-Application



At Virgil we want to ease the transition to an eldercare facility. To help you, we have created this convenient pre-application form that can be filled out electronically in Adobe Reader, or printed and handwritten. Please fill out as much of the following information as possible, and if you are unsure of an answer, please check "I don't know this information."

**Questions?** Contact our Admissions Department at (323) 665-5793 or [admissions@virgilrehab.com](mailto:admissions@virgilrehab.com)

**To submit:** Fax to (323) 665-2683 or mail to Virgil Admissions Dept, 975 North Virgil Avenue, Los Angeles, CA 90029

FIRST NAME OF RESIDENT	MI	LAST NAME
RESIDENT PHONE NUMBER	RESIDENT EMAIL	
FIRST NAME OF PERSON FILLING OUT FORM	MI	LAST NAME
PHONE FOR PERSON FILLING OUT THIS FORM	EMAIL FOR PERSON FILLING OUT THIS FORM	

Person Filling out this form:

- Patient, filling out form for self
- Family Member RELATION: \_\_\_\_\_
- Legal Guardian
- Discharge Planner HOSPITAL: \_\_\_\_\_
- Durable Power of Attorney: Health Care
- Durable Power of Attorney: Financial
- None of the Above: \_\_\_\_\_

## Resident Identification Information

<b>Gender</b> <input type="radio"/> Male <input type="radio"/> Female	<b>Age</b> _____	<b>Medical Record Number</b> _____	<b>Assessment Date</b> _____
<b>Diagnosis</b> (e.g. "Dementia" or "Aphasic") _____	<b>Medicare days used for this period of illness:</b> _____	<b>Proposed Admission Date</b> _____	
<b>Current Hospital or Skilled Nursing Facility</b> if Applicable: _____	<b>Phone #:</b> _____	<b>Admit Date:</b> _____	<b>Discharge Date:</b> _____
<b>Prior Skilled Nursing Facility or Swing Bed Use</b> if Applicable: _____	<b>Phone #:</b> _____	<b>Admit Date:</b> _____	<b>Discharge Date:</b> _____

## Medicare Technical Eligibility

I don't know this information

<b>Three day hospital stay:</b> <input type="radio"/> Yes <input type="radio"/> No	<b>Within 30 day transfer period:</b> <input type="radio"/> Yes <input type="radio"/> No	<b>Medicare days available:</b> <input type="radio"/> Yes <input type="radio"/> No	<b>Medical Appropriateness:</b> <input type="radio"/> Yes <input type="radio"/> No
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Pre-Application NAME: \_\_\_\_\_

Please check all the answers that apply. If you do not know an answer, please check "I don't know this information."

## Rehabilitation I don't know this information

Within the first 15 days of admission, will the resident receive one or more of the three therapies (Physical, Occupational, or Speech) for at least 8 days for a total of at least 240 minutes?  
 Yes  No

Within the first 15 days of admission, will the resident receive one or more of the three therapies (Physical, Occupational, or Speech) for at least 5 days for a total of at least 75 minutes AND receive at least 2 Nursing Rehabilitation Services (NRS) for at least 15 minutes each with each administered at least 2 days?  
 Yes  No

*(NRS includes: range of motion, splint or brace assistance, amputation care, training in dressing or grooming, eating or swallowing, walking or bed mobility, transfer, communication, bladder retraining, or scheduled toileting.)*

## Extensive Services I don't know this information

### In the last 7 days, did the resident have/receive:

Parenteral or IV nutrition

### In the last 14 days, did the resident have/receive:

- IV Medication  
*(Does not include fluids w/o medication)*
- Suctioning
- Tracheostomy care
- Ventilator or respirator treatment

## Special Care I don't know this information

### In the last 7 days, did the resident have/receive:

- Two or more ulcers (any type or stage) and two or more skin treatments
- Stage 3 or 4 pressure ulcer and two or more skin treatments
- Lesions other than ulcers, rashes, or cuts
- Surgical wounds
- Surgical wound care
- Application of dressings with or without topical medication (other than to feet)
- Application of ointment or medication (other than to feet)
- Fever with vomiting
- Fever with weight loss
- Fever with dehydration
- Feeding tube with aphasia  
*With total calories at least 51%, or 26%-50% and at least 501cc fluid enteral intake.*
- Respiratory therapy for 7 days

### In the last 14 days, did the resident have/receive:

Radiation therapy or implant

### Does the resident currently have:

- Multiple Sclerosis
- Quadriplegia
- Cerebral Palsy

## Clinically Complex I don't know this information

### Does the resident currently have:

- Comatose condition
- Hemiplegia/Hemiparesis
- Pneumonia
- Septicemia
- Diabetes and injections for 7 days and Doctor order changes at least 2 days

### In the last 7 days, did the resident have/receive:

- Dehydration
- Internal Bleeding
- Feeding tube  
*With total calories at least 51%, or 26%-50% and at least 501cc fluid enteral intake.*
- Burns (second or third degree)
- Treatment for foot wound

### In the last 14 days, did the resident have/receive:

- Chemotherapy
- Dialysis
- Oxygen therapy
- Transfusions
- Doctor order changes for at least four days and at least one day's visit
- Doctor order changes for at least two days and at least two day's visit

## Activities of Daily Living

 I don't know this information

Choose one from each column	Self Performance Rate resident's performance during the last 7 days (See legend below)	Support Provided Most support provided during the last 7 days
<b>Bed Mobility</b> How the resident moves to and from a lying position, turns side to side, and positions body while in bed	<input type="radio"/> Independent 0 <input type="radio"/> Supervision 1 <input type="radio"/> Limited Assistance 2 <input type="radio"/> Extensive Assistance 3 <input type="radio"/> Total Dependence 4 <input type="radio"/> Activity did not occur in last 7 days 8	<input type="radio"/> No setup or physical help from staff 0 <input type="radio"/> Setup help only 1 <input type="radio"/> One person physical assist 2 <input type="radio"/> Two+ person physical assist 3 <input type="radio"/> Did not occur in last 7 days 8
<b>Transfer</b> How resident moves between surfaces; i.e. to/from bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet.	<input type="radio"/> Independent 0 <input type="radio"/> Supervision 1 <input type="radio"/> Limited Assistance 2 <input type="radio"/> Extensive Assistance 3 <input type="radio"/> Total Dependence 4 <input type="radio"/> Activity did not occur in last 7 days 8	<input type="radio"/> No setup or physical help from staff 0 <input type="radio"/> Setup help only 1 <input type="radio"/> One person physical assist 2 <input type="radio"/> Two+ person physical assist 3 <input type="radio"/> Did not occur in last 7 days 8
<b>Toilet Use</b> How resident uses the toilet room (or commode, bedpan, or urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	<input type="radio"/> Independent 0 <input type="radio"/> Supervision 1 <input type="radio"/> Limited Assistance 2 <input type="radio"/> Extensive Assistance 3 <input type="radio"/> Total Dependence 4 <input type="radio"/> Activity did not occur in last 7 days 8	<input type="radio"/> No setup or physical help from staff 0 <input type="radio"/> Setup help only 1 <input type="radio"/> One person physical assist 2 <input type="radio"/> Two+ person physical assist 3 <input type="radio"/> Did not occur in last 7 days 8
<b>Eating</b> How resident eats or drinks, regardless of skill. Includes intake as nourishment by other means (e.g. tube feeding, total parenteral nutrition)	<input type="radio"/> Independent 0 <input type="radio"/> Supervision 1 <input type="radio"/> Limited Assistance 2 <input type="radio"/> Extensive Assistance 3 (Including tube fed or Total Parenteral Nutrition) <input type="radio"/> Total Dependence 4 <input type="radio"/> Activity did not occur in last 7 days 8	<input type="radio"/> No setup or physical help from staff 0 <input type="radio"/> Setup help only 1 <input type="radio"/> One person physical assist 2 <input type="radio"/> Two+ person physical assist 3 <input type="radio"/> Did not occur in last 7 days 8
<b>Self Performance Ratings:</b> <b>Independent:</b> No help or oversight –OR– Help/oversight only once or twice in last seven days. <b>Supervision:</b> Oversight, encouragement, or cueing provided 3 or more times during last 7 days –OR– supervision (3 or more times) plus physical assistance was provided only 1 or 2 times during the last 7 days. <b>Limited Assistance:</b> Resident highly involved in the activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times –OR– More help was provided only 1 or 2 times during the last 7 days <b>Extensive Assistance:</b> While the resident performed part of the activity, over last 7 day period, help of the following type(s) were provided 3 or more times: 1) weight bearing support, 2) Full staff performance during part (but not all) of the last 7 days <b>Total Dependence:</b> Full staff performance of the activity during the entire 7 days <b>Activity did not occur:</b> in the last 7 days		

I certify the above information is true to the best of my knowledge and that I have the authority to submit this information to Virgil on behalf of the prospective resident.

If you are a Hospital Discharge Planner: I further certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. I also certify that I am authorized to submit this information by this facility on its behalf.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_