



The Team Gleason House for Innovative Living is a residential facility designed to help people diagnosed with incurable neuro-muscular disorders live more independently. It is only the second residence of its kind. With the help of Chase Bank's \$350,000 grant, Team Gleason is using cutting edge technology to help mobilize and inspire people living with ALS; residents are able to open doors, turn up or down their bedroom shades, or call for the elevator, all with the help of a computer and a sensor that tracks head/eye movement for instruction.

The Team Gleason House for Innovative Living is located at St. Margaret's Skilled Nursing Residence in New Orleans, Louisiana, the first floor of the new facility is a dedicated ALS specialty care neighborhood. A specially trained staff will care for the residents.



ST MARGARET'S

The Team Gleason House for Innovative Living  
at St. Margaret's Skilled Nursing Residence

3525 Bienville St.  
New Orleans, LA 70119  
504.279.6414

### APPLICATION

Applicant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Race: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Previous Occupation: \_\_\_\_\_

Religion: \_\_\_\_\_ Church: \_\_\_\_\_ Minister: \_\_\_\_\_

Present Living Arrangements: Lives Alone With Family Nursing Home

Has applicant previously lived in a nursing home: Yes No If so, how long ago? \_\_\_\_\_

Which facility? \_\_\_\_\_

Social Security #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Effective Date Part A: \_\_\_\_\_ Part B: \_\_\_\_\_

HMO / PPO: \_\_\_\_\_ Secondary Insurance Provider: \_\_\_\_\_

### Applicant Care Information

#### Health

Is/was applicant in hospital? Yes No

Name of hospital: \_\_\_\_\_ Date from: \_\_\_\_\_ to: \_\_\_\_\_

Name of applicant's physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Will physician continue to treat the applicant in The Team Gleason House? Yes No

Has the applicant ever received any psychiatric treatment? Yes No

If so, by whom? \_\_\_\_\_

Do you give St. Margaret's permission to contact this person to obtain additional information? Yes No

Has applicant been diagnosed with ALS? \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_ Has applicant ever been informed of any other specific medical diagnosis? \_\_\_\_\_

Does the applicant have a Living Will (Advance Directive)? Yes No

Does someone have a legal Durable Power of Attorney (medical decision making)? Yes No

If so, name of person: \_\_\_\_\_

### Functional Capacity

Applicant's height: \_\_\_\_\_ Weight: \_\_\_\_\_

Does applicant require assistance with walking? Yes No

Does applicant use: walker cane crutches wheelchair scooter

Applicant requires assistance with the following: eating dressing bathing transfers toileting

Does applicant have control of bowels? Yes No Bladder? Yes No

Does applicant require catheter care? Yes No

Does applicant regularly experience problems with constipation? Yes No

Does applicant regularly experience problems with diarrhea? Yes No

Does applicant have experience any pain and/or spasticity? Yes No

If so, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Vision

Does applicant wear glasses? Yes No

Applicant's vision: good good with glasses adequate poor blind

Is there a specialist (ophthalmologist, surgeon) that we should contact if we are in need of a consultation?

\_\_\_\_\_  
Please describe any visual impairment: \_\_\_\_\_

\_\_\_\_\_

### Hearing

Does the applicant use a hearing aid? Yes No

Applicant's hearing: good adequate poor uses a hearing aid deaf

### Speech

What language does the applicant speak? \_\_\_\_\_

Is the applicant still able to speak? \_\_\_\_\_

Level of difficultness in understanding the applicant's speech:

easy to understand    almost no difficulties    somewhat difficult    very difficult

Does the applicant currently use any technology to assist with speaking?    Yes    No

Please list current technology: \_\_\_\_\_

Would the applicant benefit from using technology?    Yes    No

Does the applicant wear dentures?    Yes    No

### **Diet and Swallowing**

Does applicant require a special diet?    Yes    No

Does the applicant have a swallowing disorder? Please describe: \_\_\_\_\_

What type diet/restrictions? \_\_\_\_\_

Favorite Foods: \_\_\_\_\_

### **Emotional/Social**

Has the admissions process for the Team Gleason House been at free will of the applicant?    Yes    No

Has applicant been:    confused    withdrawn    anxious    agitated    noisy    moody

cooperative    depressed    striking out at others    exceptionally happy

Does applicant have any history of mental/emotional disorders? \_\_\_\_\_

How does applicant feel in social situations with persons diagnosed with the same condition as their own?

With other conditions? \_\_\_\_\_

Has the applicant ever been suicidal or treated for suicidal ideation?    Yes    No

Does applicant have a mental health professional to talk to (counselor, psychologist, social worker)?    Yes    No

Does applicant have strong support system of family and friends?    Yes    No

Please describe \_\_\_\_\_

### **Activities**

What activities does the applicant usually enjoy?

reading    television    singing    music    parties    dancing    sports    cards    handicrafts

exercise    puzzles    going to church    browsing the internet    exploring technology    research

socializing    movies    self help group    other: \_\_\_\_\_

What time does applicant usually go to bed? \_\_\_\_\_ Wake in the morning? \_\_\_\_\_

Does the applicant prefer an evening or a morning bath? \_\_\_\_\_

Describe applicant's daily routine: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe what the applicant enjoys *most* about their daily routine: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe what the applicant enjoys *least* about their daily routine: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **ALS Specific**

Please describe physical status: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does applicant have a ventilator? Yes No

Does applicant plan on having a ventilator? Yes No Undecided

What does applicant currently have/use? Bi Pap Machine Feeding Tube DPS

Date of last exacerbation: \_\_\_\_\_

Neurologist: \_\_\_\_\_

What ALS needs are most critical right now? \_\_\_\_\_

\_\_\_\_\_

What one thing would help the applicant feel most at home here at the Team Gleason House?

\_\_\_\_\_

\_\_\_\_\_

Please list any other ALS specific information we should know: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Finances**

**(Financial information is not a factor in the applicant's acceptance.)**

Please list sources and approximate amount of applicant's *monthly* income:

Social Security Income: \_\_\_\_\_

Retirement/Pension Income: \_\_\_\_\_

Interest Income: \_\_\_\_\_

Other: \_\_\_\_\_

Name of Mortuary: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Responsible Party**

Name: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Primary Caregiver (if different)**

Name: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Person Filling Out Application (if different)**

Name: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

**Other Contact**

Name: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

