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.

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: _____

_____

_____

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_____

**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: _____

**Any further information you would like to add:**

_____

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**Thank you for your interest in The Team Gleason House for Innovative Living.**

**Please submit all applications to:**

**Marianna Dion**
**mdion@stmargaretsno.org**

**3525 Bienville St.**
**New Orleans, LA 70119**

**Once you submit your application, St. Margaret's will be in touch with you.**

**NO WHITE FLAGS**