City of Vancouver Human Resources
415 W 6th St – 3rd Floor/P.O. Box 1995
Vancouver, WA 98668-1995
P: 360.487.8403 F: 360.487.8418
Email: April.Stinson@cityofvancouver.us

Application Request

(To Be Completed by Member, Family Member or Legal Rep – please check one)

☐ Home Health Care ☐ Skilled Nursing Home Care Services ☐ Other_____

Name:	SSN:	Telephone Number:
Complete address including zip code:	Pension Board: ☐ Police ☐ Fire	Status: ☐ Active ☐ Retired
Medical Insurance: ☐ Kaiser Permanente ☐ Blue Cross ☐ Other _____	Veteran? ☐ Yes - Branch of Svc _____ ☐ No	

QUICK PERSONAL ASSESSMENT TOOL

(TO BE COMPLETED BY MEMBER, FAMILY MEMBER OR LEGAL REPRESENTATIVE)

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Bathing or Showering	☐	☐	☐
Dressing	☐	☐	☐
Transferring	☐	☐	☐
Continence	☐	☐	☐
Shaving, Hair Care	☐	☐	☐
Preparing Meals	☐	☐	☐
Transportation	☐	☐	☐
Housekeeping	☐	☐	☐
Personal Laundry	☐	☐	☐

Current Living Situation: ☐ Home (alone) ☐ Home (with services) ☐ Lives with family
☐ Hospital ☐ Other _____

Walking Ability: ☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☐ Not Mobile

Memory Loss: ☐ Frequent loss ☐ Occasional loss ☐ No memory loss ☐ Dementia Diagnosis
☐ Alzheimer's Diagnosis

ADDITIONAL INFORMATION

What recent conditions or events have occurred causing you to consider a change in your circumstance? Please be specific.

I hereby certify, under the penalty of perjury in the State of Washington, that this application contains no willful misrepresentation, and that the information is true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

Print Name: _____ Relationship to Member: _____

April Stinson | 360-487-8403 | April.Stinson@cityofvancouver.us
P.O. Box 1995 | Vancouver, WA 98668-1995 | cityofvancouver.us

City of Vancouver Human Resources
415 W 6th St – 3rd Floor/P.O. Box 1995
Vancouver, WA 98668-1995
P: 360.487.8403 F: 360.487.8418
Email: April.Stinson@cityofvancouver.us

Physician's Statement

LEOFF I Member Name:	SSN:	Birthdate:

*The LEOFF I member, as listed above, has applied to the City of Vancouver Pension Board for approval of medical services. Please complete and sign the **PHYSICIAN** section of the form as listed below.*

Diagnosis:	Prognosis:

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Bathing or Showering	☐	☐	☐
Dressing	☐	☐	☐
Transferring	☐	☐	☐
Continence	☐	☐	☐
Shaving, Hair Care	☐	☐	☐
Preparing Meals	☐	☐	☐
Transportation	☐	☐	☐
Housekeeping	☐	☐	☐
Personal Laundry	☐	☐	☐

Walking Ability: ☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☐ Not Mobile

Memory Loss: ☐ Frequent loss ☐ Occasional loss ☐ No memory loss
☐ Dementia Diagnosis ☐ Alzheimer's Diagnosis

Based on the needs of this patient, I would recommend the following type of service (please check one):

☐ Home Health Care ☐ Assisted Living ☐ Long Term Custodial Care ☐ Skilled Nursing

☐ Other_____

Based on the needs of this patient, I would recommend the following level of care (please check one):

☐ Skilled Care: nursing care performed under the orders of a doctor, supervised by a licensed registered nurse or practical nurse available around the clock on a daily basis. A person with professional training or skills must perform most daily procedures.

☐ Intermediate Care: nursing care performed under the orders of a doctor and under supervision of a licensed registered nurse or practical nurse. The patient is provided with skilled care on a periodic basis. These periodic procedures cannot be done without professional training or skill.

☐ Custodial Care: primarily meets the personal needs of the patient and can be provided by a person without professional training or skill.

Frequency of Need: _____ (#) hours a day, _____ (#) days a week

Duration (how long do you anticipate need): ☐ Less than 2 weeks ☐ 3 – 4 weeks

☐ 1 – 3 months ☐ 4 – 6 months ☐ over 6 months ☐ not sure ☐ other_____

ADDITIONAL INFORMATION

Please provide any additional opinions on the specific medical and other assistance this patient needs:

Physician's Signature: _____ Date: _____

Typed or Printed Name_____ Phone: _____

Physical Address, including zip code:	Mailing Address, including zip code:

April Stinson | 360-487-8403 | April.Stinson@cityofvancouver.us
P.O. Box 1995 | Vancouver, WA 98668-1995 | cityofvancouver.us