Harold Sherman Adult Day Center

Application for Enrollment Adult for Day Care/ Day Health Services

Applicant's full name:_____

Address: _____

Phone: _____ DOB: _____ Sex: ____ SSN: _____

Information About Applicant

Why are you interested in coming to this program? _____

_____

Have you had previous experience in a Day program? ___Yes ___No

If yes, where and when? _____

Do you have any personal concerns or information that may impact on our provision of care to this participant?

□ No □ Yes If Yes, Please Explain: _____

_____

Marital Status: ___Married ___Single ___Separated ___Widowed ___Divorced

Present Living Arrangements: ___With spouse ___With relatives ___With Non-Relatives

___Alone in House or Apartment ___Alone in Single Room

If living with someone employed, employer: _____

Work Phone: _____ Home Phone: _____Cell Phone:_____

Home Address: _____

Emergency Care Information

Please list the names of two persons who may be contacted in case of emergency:

_____ _____

(1) Name Relationship to Applicant

_____ _____

Address Telephone / Cell Phone Number(s)

_____ _____

(2) Name Relationship to Applicant

_____ _____

Address Telephone / Cell Phone Number(s)

Name of Physician: _____ Telephone: _____

Name of Dentist: _____ Telephone: _____

Services and Agreements

Transportation will be provided by: □ Relative or Friend _____
□ Public/Private Transportation: Name _____
□ Day Care Program

I agree that participation in this program will be paid by:
___ Department of Social Services ____ CAP/Medicaid ____ Veterans Administration
____ Participant ___ Caregiver/Relative Name: _____
____ Other _____

Days of Attendance: (Please Circle) M T W Th F

Arrival Time: _____ Departure Time: _____

Special dietary needs, if any: _____

(Attach a copy of the doctor's orders if on a therapeutic diet)

Supportive devices used by applicant:

□ Cane □ Walker □ Wheelchair □ Hearing aid □ Dentures

□ Eyeglasses (contacts) □ Other, please list: _____

Service Agreement

□ This participant does not require a POA, may make his/her own medical or other decisions, and may sign for his/herself legally.

□ Participant (named below) has a Power of Attorney or legal guardian (POA document shown) □

Name of POA/guardian_____ Phone # of POA/guardian_____

□ Participant has an advance directive

□ I will provide the day program with and original copy.

□ Participant does not have an advance directive.

□ I would like information on how to obtain an advance directive.

□ Participant does not want an advance directive.

□ Participant has a DNR order.

□ I will provide the day program with an original copy.

□ The Healthcare Coordinator will administer medications, if needed, as prescribed. I will provide these medications in the containers as dispensed with their proper labeling as per state requirements. All medications will be locked and distributed at time prescribed.

□ It is the responsibility of the participant and/or responsible party to notify the Center of any changes in medication, health conditions, etc.

□ I have received a copy of my Participants Rights in my enrollment packet.

 I agree to adhere to the program requirements by having an annual physical and tuberculin skin test or physician verification of being free of communicable disease. The results will be maintained as a part of my confidential program health records. I hereby authorize/ not authorize the Harold Sherman Adult Day Center to use my pictures, video, slides or tape recording of me for publicity, our in-house photo album and/or news releases relating to the Harold Sherman Adult Day Center.

 I hereby authorize the Harold Sherman Adult Day Center to take photographs and create a "scent- pack" to be confidentially maintained and used only for identification purposes. I authorize my name with these forms of identification.

 The Harold Sherman Adult Day Center has my permission to transport this participant on field trips and/or to and from the facility as needed. I will be notified by staff of each field trip.

 All items brought to the Center must be marked. The Harold Sherman Adult Day Center will not be held responsible for missing or lost items.

 If emergency medical care becomes necessary, I give permission for any treatment the physician deems necessary.

 The day care program's policies have been explained to me and I have been given a copy of them and agree to abide by them.

 I acknowledge that I have received Granville Health System/ Harold Sherman Adult Day Center's Notice of Privacy Practices. I understand that the notice and disclosures of my protected health information by Granville Health System/ Harold Sherman Adult Day Center informs me of rights and respect of my protected health information. A signed authorization and specifics regarding the release of information will be signed at each information request, when indicated by law.

Applicant Signature:_____ Date: _____

Responsible Party Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Granville HEALTH SYSTEM
Quality Care...Close To Home

HAROLD SHERMAN ADULT DAY CENTER
APPLICANT MEDICAL INFORMATION
to be completed by your physician

The individual listed below desires or has enrolled in a Day Program for Adults. Supervision is provided during the day for disabled and elderly adults in a protective setting to promote social, physical and emotional well-being; personal care and to offer opportunities for companionship, self-education and other leisure time activities. The **Harold Sherman Adult Day Center** has been approved by the State Department of Health and Human Resources, Division of Aging and Adult Services to provide these services. In order to protect both the applicant and other participants, it is necessary that we have medical information on each person. This information will also assist the Day Activity personnel in working with this person.

Patient's Name: _____Birth Date: _____
Most Recent Date Seen by a Doctor: TB Test Results [optional]: Positive Negative Date of Test:
Blood Pressure: Pulse/Respiration: Weight:

PHYSICAL HEALTH STATUS:	No	Yes	If Yes, Please Comment
Arthritis, Rheumatism	☐	☐	_____
Asthma	☐	☐	_____
Emphysema, Chronic Bronchitis	☐	☐	_____
Tuberculosis	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Condition	☐	☐	_____
HIV	☐	☐	_____
Circulation Problems	☐	☐	_____
Stomach Ulcers	☐	☐	_____
Diabetes	☐	☐	_____
Gastro-Intestinal Problems	☐	☐	_____
Urinary Tract Problems (include bladder incontinence)	☐	☐	_____
Anemia	☐	☐	_____
Effects of Stroke	☐	☐	_____
Epilepsy	☐	☐	_____
Glandular Disorders	☐	☐	_____
Allergies, Allergic Reactions	☐	☐	_____
Skin Disorders	☐	☐	_____
Communicable Diseases	☐	☐	_____
Cancer	☐	☐	_____
Amputation	☐	☐	_____

Other _____

Primary Diagnosis: _____ Secondary Diagnosis:_____

☐ Malnourishment ☐ Change in Bowel Habits ☐ Shortness of Breath
☐ Lumps ☐ Blood in Urine ☐ Dizziness
☐ Persistent Cough ☐ Hearing ☐ Vision
☐ Severe Headaches ☐ Sudden Weight Loss ☐ Other
☐ Vomiting ☐ Severe Chest Pains

Medicine Patient is taking for physical health problems (continued on Page 2)

Medicine	Dosage	Frequency

 PATIENT'S NAME: _____

CONTINUED: Medicine Patient is taking for physical health problems

Medicine	Dosage	Frequency

Use additional sheet if necessary

MENTAL HEALTH STATUS:

Organic Brain Damage: ☐ Yes ☐ No Arteriosclerosis: ☐ Yes ☐ No Personality Disorders: ☐ Yes ☐ No

Other:_____

☐ Loss of Appetite
☐ Insomnia
☐ Feeling of Worthlessness
☐ Loss of Interest
☐ Hypochondria
☐ Suspiciousness
☐ Hallucinations
☐ Delusions
☐ Distortion in Thinking
☐ Confusion
☐ Impaired Judgment
☐ Memory Loss
☐ Orientation Problem
☐ Hazardous Behaviors
☐ Alcohol Abuser
☐ Drug Abuser

Medications patient is taking for mental health problems:

Medicine	Dosage	Frequency

GENERAL INFORMATION:

☐ Does this person require constant supervision to make sure harm is not done to self, others or property? Yes No
☐ Will this person wander off if not closely attended? ☐ Yes ☐ No
☐ Can this person do light exercises from a sitting position, such as leg lifts, arm lifts, etc? Yes No
☐ Do you recommend any special type of activities for this client, such as group social activities, craft activities, physical exercise, training in self-care? ☐ Yes ☐ No
☐ Has this person had a pneumonia vaccine? ☐ Yes ☐ No Date of vaccine _____ If no, would they benefit from one and can they receive one during this visit? ☐ Yes ☐ No Vaccine received date _____
☐ Is a special diet or other special regimen required for this patient? ☐ No ☐ Yes, if yes please attach or describe:
_____

Please comment on any physical, mental or emotional condition apparent from your knowledge of the above named person that might need further explanation or might affect other participants.

_____

_____

Complete referral form for any Rehabilitation Services recommended.

I certify that I have today reviewed the health history and examined this person and find him/her physically able to participate in an adult day care activity program.

Signed: _____ Date: _____

M.D., P.A. or Nurse Practitioner

Address: _____ City: _____

Phone: (_____)_____

HAROLD SHERMAN ADULT DAY CENTER MEDICINE LIST/WAIVER

To be prepared for the emergencies that can and do happen, please list below all medications being taken either at the Center or at home by the participant. This will provide the rescue squad with the vital medical information that is necessary to administer proper treatment. It is important that the staff at the Center be given in writing any changes in medication to keep our records current.

I hereby authorize the personnel of **Harold Sherman Adult Day Center** to administer the medicine(s) listed below. In doing so, I hereby release said program, its officers, staff and personnel, from any and all liability that might arise as a result of the medication being administered and hereby waive any action which I may have as a result of the medication being administered. I will be notified when the medicine supply is low. Furthermore, I release the fore said from any and all liability that might arise as a result of said medication not being administered because the supply was not replenished.

Participant's Name: _____

If Taken at the Program	Times Given at Program	Name of Medication	Dosage	Frequency	Route	Notes
		Use back if necessary				

Over-the-counter medication(s) ordered by Physician: (Physician's order with dosage & instructions are required):
_____

Allergies: _____

Medication Policy:
State regulations prohibit administering any medication not in the original container from the doctor or pharmacy. North Carolina Adult Day Care Standards for Certification state that medications kept by the program shall be in containers in which they were dispensed from the pharmacy. The containers shall be clearly labeled with the participant's full name, the name and strength of the medicine, and dosage and instructions for administration. Only medications that meet this stated criterion will be given. Most pharmacies will give two containers if asked. Pills brought to the center in envelopes, pills boxes or other containers not meeting the above description cannot be given. Harold Sherman Adult Day Center requires any over the counter medications be accompanied by a physician's order when dispensed at the program.
With everyone's safety in mind, it is necessary to strictly comply with this policy. It is not intended to be a hardship on anyone. Thank you for your cooperation.

Participant's Signature: _____ Date: _____

Guardian/Medical POA's Signature: _____ Date: _____

HAROLD SHERMAN ADULT DAY CENTER
COMPREHENSIVE SOCIAL AND ACTIVITY ASSESSMENT

BACKGROUND INFORMATION

Personal Information/Preferences:

Name _____ Nickname/ Preferred Name: _____

Birthdate: _____ Birthplace: _____

Marital Status: ☐ M ☐ D ☐ W ☐ S If married, spouse's name _____

Children's Names: _____

Language Spoken: _____ Speech: ☐ Clear ☐ Unclear, Explain: _____

Education: _____ ☐ Read ☐ Write Veteran? ☐ Yes ☐ No

Former Occupation: _____

Economic Status: Current Income -Monthly _____ Annual _____
Income Sources: S.S. ___ Pension ___ VA Benefits ___ Other- List _____
Refused to Provide ____

Clubs/Organizations: _____

Voting Interests: Registered Voter? ☐ Yes ☐ No Active Voter? ☐ Yes ☐ No

Use of Tobacco Products? ☐ Yes ☐ No Type/Usage: _____

Use of Alcohol? ☐ Yes ☐ No Type/Usage: _____

Spiritual Involvement: Church/religious preference: _____

Level of Participation: _____

When would you prefer to participate in scheduled activities? ☐ Morning, after breakfast

☐ Afternoon, after lunch ☐ None of these, Explain_____

What time do you get up in the morning? _____ Go to bed at night? _____

Do you take naps? ☐ Yes ☐ No If yes, what time of day and how long? _____

Would you like to have a service –related job assignment? ☐ Yes ☐ No
If yes, what type? _____
☐ Sweeping ☐ Cleaning tables ☐ Folding Linens ☐ Water Plants ☐ Arranging Magazines/books/videos
☐ Bulletin board decorating ☐ Flower arranging

ACTIVITY PURSUIT PATTERN

(**P**- Past interest; **C**- Current interest; **N**-No interest)

P	C	N	ACTIVITY	P	C	N	ACTIVITY	P	C	N	ACTIVITY
			Cards				Spiritual Activities				Helping Others/ Volunteer work
			Games				Outings				Parties/ Social Events
			Arts/crafts				Shopping				Radio
			Exercise				Walking/Wheeling Outdoors				Hobbies
			Sports				Watching TV				Community Outings
			Music				Watching movies				Groups/Organizations
			Reading				Gardening/Plants				Other:
			Writing				Talking/Conversing				Other:

ACTIVITIES OF DAILY LIVING

Participant **can** carry out the following tasks **without help**:

1. Prepare meals ☐ YES ☐ NO
2. Shop for personal items ☐ YES ☐ NO
3. Manage own medications ☐ YES ☐ NO
4. Manage own money (pay bills) ☐ YES ☐ NO
5. Use telephone ☐ YES ☐ NO
6. Do heavy housework ☐ YES ☐ NO
7. Do light cleaning ☐ YES ☐ NO
8. Transportation ability ☐ YES ☐ NO
9. Eat without assistance ☐ YES ☐ NO
10. Get dressed ☐ YES ☐ NO
11. Bathe self ☐ YES ☐ NO
12. Use the toilet ☐ YES ☐ NO
13. Transfer into/out of bed/chair ☐ YES ☐ NO
14. Ambulate (walk or move about the house without anyone's help) ☐ YES ☐ NO

TOTAL IADL'S & ADL'S (add # of Yes's) _____

PHYSICAL STATUS

Vision: ☐ Good ☐ Poor ☐ Sees well with glasses ☐ Other: _____

Hearing: ☐ Good ☐ Poor ☐ Deaf ☐ Uses hearing aid
Hears best in: ☐ Right ear ☐ Left ear

Mobility: Ambulates ☐ Independent ☐ With assistance ☐ Cane ☐ Walker
☐ Wheelchair, manual ☐ Motorized wheelchair

Arm Function: Right: ☐ Full ☐ Partial ☐ None Left: ☐ Full ☐ Partial ☐ None

Hand Function: Right: ☐ Full ☐ Partial ☐ None Left: ☐ Full ☐ Partial ☐ None

Leg Function: Right: ☐ Full ☐ Partial ☐ None Left: ☐ Full ☐ Partial ☐ None

Elimination: ☐ Continent ☐ Incontinent ☐ Catheter ☐ Colostomy ☐ Prompting

COMMUNICATION, COGNITIVE STATUS AND ATTITUDE

Ability to understand others/directions: ☐ Understands ☐ Usually understands
☐ Sometimes understands ☐ Rarely/never understands

Ability to have needs understood by others: ☐ Good verbal skills ☐ Moderate loss
☐ Non- verbal ☐ Aphasic ☐ Speech Impediment ☐ Word loss
☐ Use of pantomime or other tools

Decision-making ability: ☐ Independent ☐ Needs assistance when in new situation
☐ Moderately impaired ☐ Severely impaired

Oriented to: ☐ Person ☐ Place ☐ Time ☐ Situation ☐ Object

Short-term Memory: ☐ Good ☐ Adequate ☐ Poor
Long-term Memory: ☐ Good ☐ Adequate ☐ Poor

Is there a history of psychiatric illness? ☐ Yes ☐ No Diagnosis: _____

Currently seeing a psychiatrist? ☐ Yes ☐ No

Attitude: ☐ Enthusiastic ☐ Cooperative ☐ Cheerful ☐ Willing to Try

☐ Motivated ☐ Depressed ☐ Uncooperative ☐ Withdrawn ☐ Apathetic

Attitude towards life and activities in general: ☐ Interested ☐ Disinterested

PARTICIPANTS STRENGTHS/LIMITATIONS

Strengths: ☐ Sense of Humor ☐ Cooperative ☐ Socially Interactive
☐ Willing to Participate ☐ Willing to try new things ☐ Other: _____

Limitations: ☐ Combative ☐ Inappropriate behaviors ☐ Limited Strength
☐ Short Attention Span ☐ Other: _____
☐ Assistance Required ☐ with ADL's ☐ with tasks ☐ with reading ☐ with writing

PERSONAL GOAL STATEMENTS

The one thing I am most interested in learning/doing is _____
_____

If I could do anything I wanted, whenever I wanted I would _____
_____

I am the most happy when I am _____
_____

The one thing of which I am most proud is_____
_____

INITIAL ACTIVITY GOALS/OBJECTIVES & INTERVENTIONS

1. GOAL/OBJECTIVE: _____
_____

APPROACH/INTERVENTION:_____
_____

2. GOAL/OBJECTIVE: _____
_____

APPROACH/INTERVENTION: _____
_____

_____ _____
Program Director Signature Date

Staffing/ Date _____

Harold Sherman Adult Day Center

Before you arrive for your first day at the Center, make sure you have the following:

- ☐ All paperwork is complete and has been given to the Program Director or Healthcare Coordinator.

- ☐ Physical Exam is complete.

- ☐ Bring at least one set of extra set of clothing to be kept in program. At change of seasons you may want to change out clothing for weather appropriate wear.

- ☐ Adult incontinent pads or undergarments- enough to address the daily needs of your loved one.

- ☐ Mark all items that can be "taken off" with participant's name- i.e., clothing, coats, hats, scarves, sweaters, eye glasses. We urge you to not send purses or wallets with your loved one. If you do, we cannot be responsible for lost items. Keep important documents and money at home.

- ☐ Medications to be taken in program must have current pharmacy label, including: Participant's name, name and strength of medication; dosage and instructions. All over-the-counter medications must also have a Dr.'s prescription or pharmacy label.