



PARTICIPANT'S INTAKE INFORMATION SHEET

NAME: _____

ADDRESS: _____
 _____ ZIP: _____

PHONE: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: ____/____/____ MARITAL STATUS: _____

Living Arrangements: Independent Caregiver

Veteran: Yes No Legal Resident: YES NO

Personal Physician: _____

Physician's Fax: _____ Physician's Phone: _____ Hospital: _____

Religious Preference: _____ Pastor/Church: _____

RESPONSIBLE PARTY

Name: _____ Relationship: _____

StreetAddress: _____ City: _____ OK ZIP _____

Home #: _____ Work #: _____ Cell Phone/Pager: _____

Email: _____ Fax: _____

PRIMARY EMERGENCY CONTACT: (if other than Responsible Party)

Name: _____ Relationship: _____

StreetAddress: _____ City: _____ OK ZIP _____

Home #: _____ Work #: _____ Cell Phone/Pager: _____

Email: _____ Fax: _____

OTHER EMERGENCY CONTACTS:

2) Name: _____ Relationship: _____

StreetAddress: _____ City: _____ St _____ Zip _____

Home #: _____ Work #: _____ Cell Phone/Pager: _____

Email: _____ Fax: _____

3) Name: _____ Relationship: _____

StreetAddress: _____ City: _____ OK ZIP _____

Home #: _____ Work #: _____ Cell Phone/Pager: _____

Email: _____ Fax: _____

I learned about the Daily Living Centers from: Television, Radio, Newspaper, Friend, United Way, Family Member, Physician, Other _____

FOR CENTER USE ONLY DNR - <input type="checkbox"/> YES <input type="checkbox"/> NO Initial Date/Time: _____ Projected Start Date: _____ Discharge Date: _____ Rock: ____ South: ____ Ed: ____ Jeltz: ____ Days: _____ S M T W T F S Payment: PP VA DHS ADV SCH Transportation: FAM DLC MET N/A PICTURE: _____ MEAL: _____
--

PARTICIPANT'S INTAKE INFORMATION SHEET

NAME: _____

Participant's gross monthly income: _____ Combined income, if married : _____

Eligible for DHS assistance: Yes No Date Filed for DHS Assistance _____

DHS Case Number _____ Caseworker: _____

Co-Pay _____ Number of Days Per Month Approved _____

Medicare Number: _____ A or B Medicaid Number: _____

Insurance Company: _____ Policy Number: _____

Responsible Party _____ Relationship _____

Address: _____ City/State _____

CHECK ALL THAT APPLY:

Living Will Power of Attorney Durable Power of Attorney Conservator Guardian

ADMISSION AGREEMENT

I understand that my acceptance into the Daily Living Centers, Inc. program is provisional and that I will be evaluated for two weeks by the staff of the Center for appropriateness of this program for me.

Further, I understand that I might not be accepted into the Daily Living Centers, Inc. program after the provisional period for the following reasons:

- 1) I do not respond to the program.
- 2) I have some behavior(s) that interfere with the operation of the program.
- 3) I experience a physical or mental condition that indicates another level of care.

In addition, I understand that if I have any living habit or behavior that is disruptive to the group that my continuance in the program will depend upon my correcting this problem. I understand that the Daily Living Center and my family will work with me to correct difficulties and failing improvement, I will be discharged from the program.

Date

Signature of Participant or Guardian

RIGHTS OF ADULT DAY CARE PARTICIPANTS

Name: _____

Each participant of the Daily Living Centers, Inc., shall be assured of the following rights:

1. To be treated as an adult with respect and dignity regardless of race, color, or creed.
2. To participate in a program of services and activities which promote positive attitudes regarding one's usefulness and capabilities.
3. To participate in a program of services designed to encourage learning, growth and awareness of constructive ways to develop personal interests and talents.
4. To maintain independence to the extent possible, and to be involved in a program of services designed to promote personal independence.
5. To be encouraged to attain self-determination, including the opportunity to participate in developing one's care plan for services, to decide whether or not to participate in any given activity, and to be involved, to the extent possible, in program planning and operation.
6. To be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided.
7. To have privacy and confidentiality.
8. To be free of mental and physical abuse.
9. To have access to a telephone to make or receive calls, unless the family indicates necessary restrictions.
10. To be free of interference, coercion, discrimination or reprisal.

Date

Signature of Participant or Guardian

Please tell us as much about yourself as possible in order for us to plan programs and activities that interest and benefit you.

Name: _____ **Spouse's name:** _____

DOB: _____ **Birth Place:** _____

No of Years Married: _____ **Maiden Name:** _____

Married in: City: _____ **State:** _____

Children (number): _____ **Names:** _____

Places lived: _____

Places traveled: _____

Occupation (s): _____

Activities of Interest:

Games Pets/Animals Television Gardening Music Arts & Crafts

Sports Woodworking Handiwork Movies Exercise Walking

Reading Museums Shopping Sewing Cooking Puzzles

Others: _____

Clubs, Organizations and Volunteerism: _____

RELEASE OF RESPONSIBILITY

I would like to attend the **Daily Living Centers, Inc.** and participate in the regularly scheduled activities. I acknowledge my participation in all activities sponsored by the Daily Living Centers, Inc. as voluntary and will not hold the Center nor any employees or volunteers responsible for any illness or accidents, which may occur while I am a participant in the program. I understand that any financial liability incurred due to transport, treatment or extended care resulting from an accident or illness while in attendance at the Daily Living Centers, Inc. is my sole responsibility.

I further understand that if I wander away from or leave the facility without consent of the staff, I will not hold the Daily Living Centers, Inc. or any employees or volunteer responsible for illness or accidents, which may occur.

Date

Signature of Participant / Guardian

ADDITIONAL SERVICES AGREEMENT

As a part of my attendance at the Daily Living Centers, Inc., I hereby request the following additional services are provided me. I understand that I am fully responsible for the cost of such services and understand that I will be billed separately for these costs by the agency providing the service.

- Physical, Speech, and/or Occupational Therapy Services
- Mental Health Counseling Services
- Home Health Services
- No additional services requested

Date

Signature of Participant / Guardian

PUBLICITY RELEASE

(Please check one)

I hereby consent to and authorize the use and reproduction by the Daily Living Centers, Inc., or anyone authorized by the Center, for any and all photographs that you have taken of me for purposes connected with the publicity of the Daily Living Centers, Inc., without further compensation to me. The photographs and negatives shall constitute your sole property.

I DO NOT consent to NOR authorize the use and reproduction by the Daily Living Centers, Inc., or anyone authorized by the Center, for any and all photographs that you have taken of me for purposes connected with the publicity of the Daily Living Centers, Inc.

Date

Signature of Participant or Guardian

Release of Participant's Information

I _____, primary caregiver for _____ authorize the Daily Living Centers to release of information pertaining to this individual to the following people:

I understand that **only** the above listed individuals will be given information pertaining to this participant. I understand that I am responsible for keeping this list up to date and do not hold the DLC responsible if I fail to do so.

signature of caregiver

Date

Leave authorization

I _____, primary caregiver for _____ authorize the Daily Living Centers to allow the above mentioned individual to leave the DLC facility which they attend with the following people:

I understand that _____ will be allowed to leave the DLC facility with **only** the above mentioned individuals. I understand that I am responsible for keeping this list up to date and do not hold the DLC responsible if I fail to do so.

signature of caregiver

Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____
Social Security Number: _____
Date of Birth: _____

Your patient, identified above, is interested in attending the Daily Living Centers, Inc., a non-profit organization striving to promote independent functioning and social needs of older and handicapped citizens. A weekday program of services includes occupational and recreational activities, regular nurse evaluations, social services, physical therapy consultations, as indicated, planned activities, noon meals, morning and afternoon snacks, and transportation to and from the Center, if needed.

By state law, you must be advised that:

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNO-DEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (“AIDS”).

I, _____ hereby give consent to Dr. _____ (personal physician) and to _____ (hospital / facility) to release health information to the Daily Living Centers, Inc., so the Center might be informed in order to assist with my health care. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. All employees, officers, attending physicians, and physicians listed above are released from legal responsibility for the release of the requested information.

Dated this _____ day of _____, 20_____.

Signature of Witness

Signature of Participant or Guardian

Daily Living Centers, Inc.

Consent to Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations

Name of Patient/Individual: _____ Date of Birth: _____

I understand that the facility maintain, use and disclose personal health information in order to provide for my care and treatment, to arrange for billing and payment for my care and carry out general management and operations of the facility such as quality review.

I understand that these and other uses and disclosures of my personal health information are described more completely in the facility's Notice of Privacy Practices.

I understand that the facility reserves the right to change its privacy practices described in the Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information already received and maintained by the facility as well as for new information. I understand that prior to implementation, the facility will mail a copy of the revised Notice of Privacy Practices to the address I have provided. In addition, I understand that I have the following rights:

The right to receive and review the facility's Notice of Privacy Practices before signing this Consent.

The right to request restrictions on how protected health information about me is used or disclosed for treatment, payment or health care operations. The facility is not required to agree to my request, but if it does, it will be bound by its agreement.

The right to revoke this Consent, in writing, except to the extent the facility has acted in reliance on the Consent.

The right to receive a copy of this Consent form.

I consent to the use and disclosure by the Daily Living Centers, Inc. and its agents or representatives of all my personal health information for purposes of treatment, payment and health care operations.

By signing below, I acknowledge that I have read and understand this Consent form.

Signature of Participant or Participant's
Authorized Representative

Date

If signed by the Participant's Representative, please print name and describe relationship to participant:

Name

Relationship to Participant

PARTICIPANT MEDICAL HISTORY

Name: _____

List of all Diagnoses: (1)_____ (2)_____
(3)_____ (4)_____
(5)_____ (6)_____

List of all Medications and Allergies:

MEDICATIONS

ALLERGIES

(1)_____ (2)_____ (1)_____
(3)_____ (4)_____ (2)_____
(5)_____ (6)_____ (3)_____
(7)_____ (8)_____ (4)_____

Past Surgeries and Dates:

(1)_____ Date: _____
(2)_____ Date: _____
(3)_____ Date: _____
(4)_____ Date: _____

History of TB or Positive TB Skin Tests? []Yes []No

At Risk for HIV Infection? []Yes []No

Weight Loss or Gain in the last 6 months? []Yes []No

Is there a DNR (Do Not Resuscitate) Order? []Yes []No

Have you ever experienced any of the following health problems? (Check all that apply)

- []Diabetes []Depression []Heart Disease []Heart attack
- []Heart Failure []Alzheimer’s Disease []Stroke []Inability to Speak
- []Chronic Lung Disease []High Blood Pressure []Pneumonia []Memory Problems
- []Stomach Problems []Paralysis []Bowel Problems []Joint Pain/Arthritis
- []Parkinson’s Disease []Urinary Infections []Diarrhea []Pacemaker
- []Dizziness []Osteoporosis []Incontinence []Fractures
- []Multiple Sclerosis []Seizures []Skin Problems []Anemia
- []Headaches []Constipation []Head Injuries []Thyroid Problems
- []Kidney Problems []Cancer – please specify: _____
- []Hernias – please specify location: _____
- []History of Alcoholism []History of Combativeness
- []Other Behavioural Problems: _____
- []Other Case Problems: _____

Date

Signature of Daily Living Centers’ Nurse

SAFETY ASSESSMENT WORKSHEET

Name_____

Date_____

- 1. Are you having difficulty buttoning buttons or snaps on clothing? []YES []NO
- 2. Do you require assistance when getting dressed? []YES []NO
- 3. Have you noticed a decrease in you arm strength? []YES []NO
- 4. Are you having difficulty lifting or raising you arms over your head? []YES []NO
- 5. Are you having difficulty holding kitchen utensils or feeding yourself? []YES []NO
- 6. Are you having difficulty maintaining your balance while standing, washing or putting dishes away or brushing your teeth at the sink? []YES []NO
- 7. Have you recently experienced a decrease in strength, endurance/stamina or mobility? []YES []NO
- 8. Are you having difficulty speaking and communicating your needs? []YES []NO
- 9. Is it difficult to sit on the edge of your bed without falling toward one side or another? []YES []NO
- 10. Are you having difficulty getting in and out of your bathtub? []YES []NO
- 11. Do you have difficulty getting in and out of bed? []YES []NO
- 12. Are you having difficulty walking or have you had falls recently? []YES []NO
- 13. When walking do you require assistance from a walker, cane etc.? []YES []NO
- 14. If currently using an assistive device, do you have difficulty getting in and out of a chair? []YES []NO
- 15. Do you have difficulty using your assistive device? []YES []NO
- 16. If you use a wheel chair, do you have difficulty transferring to or from your bed, recliner, toilet, etc? []YES []NO

Physician's Orders

Participant: _____

DOB: _____

Date of last physical assessment: _____

List of all diagnoses: 1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Weight & vital signs, once every month unless otherwise stated: _____

Test blood sugar 1x per month, only diabetics: _____

Other treatments: _____

Is there a DNR order: _____

Medications: (Please include dosage, times and OTC meds)

1) _____ 2) _____ Allergies: _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

Dietary needs: (please check one)

General or regular diet General diabetic diet

Sodium restricted Other: _____

My client may have any of the following on a prn basis. Please check:

Tylenol(500 mg) __ cough syrup __ antacids __

My client may receive wound care of H2O and soap for scrapes and cuts YES NO

May participate in group "chair exercises"? YES NO

May participate in chair pedaling? YES NO

May use recumbent leg/arm exercise machine? YES NO

Activity level: _____

Physician's Name: _____ phone: _____ fax: _____

Address: _____

Date

Signature of physician

DUE TO FAX PRINTING PLEASE
COMPLETE ENTIRE FORM AS
LEGIBLY POSSIBLE.