ENROLLMENT APPLICATION

Date: _____Referral Source:_____

APPLICANT INFORMATION

Name:_____Nicknam
e: _____ Maiden: _____
Address:_____City, _____ZIP____
Date of Birth _____ Age: ____ Gender: _____
Race:_____ Marital Status:____Religious Affiliation:_____
Level of Education: _____ Military Record:_____
Employment History
_____
Applicant Lives With: _____ Number in Household:
_____

DAYS NEEDED	Monday	Tuesday	Wednesday	Thursday	Friday
Full Day					
Half Day					

CAREGIVER INFORMATION

Primary Caregiver:
_____
Relationship to Applicant:
_____
Address (if different from applicant):
_____
_____
Home Phone: _____Cell Phone: _____
Email Address:
_____
Employment: _____ Work Phone_____

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_____

NAMES OF CHILDREN ADDRESS PHONE #

_____
_____
_____
_____
_____

NAMES OF SIBLINGS PHONE #

_____
_____
_____
_____

NAMES OF CLOSE FRIENDS PHONE#

_____
_____

GENERAL INFORMATION

1) Is the applicant able to self-feed? Yes _____No ___If no what assistance_____
2) Is the applicant able to self-toilet? Yes _____ No _____
If no, what assistance_____
3) Is the applicant incontinent? Yes _____ No _____ If yes, how often? _____
How do you handle incontinence? _____
*If applicant requires incontinence supplies, the family will be required to provide them.
4) Is applicant able to ambulate independently? Yes _____ No _____
If no, what assistance is needed?
_____
5) Does the applicant require a special diet? Yes _____No _____
If yes explain_____
6) Does the applicant experience agitation/hostility? Yes___No___
What situations increase agitation/hostility?
_____
7) What methods reduce agitation/hostility?
_____
8) Does the applicant wander? Yes _____ No _____
If yes, please explain: _____
9) What makes the applicant happy?
_____

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10) Does the applicant like children? Yes _____No____
Pets? Yes _____ No _____

11) What makes the applicant fearful or sad?
_____

12) What hobbies/interests does the applicant have?
_____

13) What are the applicant's favorite foods?
_____

14) What kinds of music does the applicant enjoy?
_____

15) Circle all of the following that the applicant enjoys:

Dancing	Walking	Exercising	Reading
Reminiscing	Computers	Storytelling	Movies
Being read to	Television	Arts/Crafts	Sports
Card Games	Puzzles	Woodworking	Sewing
Housework	Music	Fishing	Cooking
Gardening	Outside Activities		

16) Please share any information that would be helpful when caring for the applicant:
_____
_____
_____
_____

Caring Days

MEDICAL INFORMATION

Physician who diagnosed dementia:
Name: _____Phone: _____

Address: _____

Primary care physician:

Name: _____ Phone:

Address: _____
Other physician currently seeing the applicant:

Name: _____Phone: _____

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Current medical problems (circle all that apply):

Alcoholism	Arthritis	Asthma
Cancer	Depression	Diabetes
Digestive/Intestinal	Dizzy Spells	Drug Abuse/Dependence
Falls	Gynecological	Hearing
Heart	High Blood Pressure	Fracture/Replacement
Obesity	Osteoporosis	Respiratory Problems
Seizures	Vision Problems	Weight Loss

Other: _____

MEDICAL INFORMATION

Allergies:_____
Dietary Restrictions:_____
Psychiatric Problems: _____
Has the applicant ever been diagnosed with tuberculosis? Yes __No__
Has the applicant had a physical in the last year? Yes __
No __
Current prescription and over-the-counter medications & dosages:
_____
_____
_____
_____
_____
_____
Will medication need to be administered during day care hours? Yes __
No __
Is there any medical problem that would put the applicant at risk in the day care setting?
_____
What are you expectations for Caring Days?
_____
_____
Does the applicant have a DNR (do not resuscitate) order? Yes __
No __

*Since Caring Days is not a medical facility, we do not determine when a DNR should go into effect. For any and all severe medical emergencies we will call 911 and request medical assistance.

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MEDICAL INFORMATION

Has someone been legally assigned as guardian for the applicant? Yes __
No __
Name:_____Phone:_____
Address: _____

EMERGENCY CONTACTS & INFORMATION

Primary Contact:
Name:_____
Address: _____
Home # _____ Work # _____
Cell # _____
Secondary Contact:
Name: _____Phone # _____
Physician:
Name: _____ Phone:_____
Hospital Preference:
_____
If you prefer using the Northport DCH, paramedics advise us that if there is a heart problem, they will send them back to DCH Regional Medical Center. If the paramedics feel that it would be better to take them to one hospital, over the other due to the type of medical problem or the time element, do you want the paramedics to make that decision? Yes _____
No _____
Type of Insurance: _____Caregivers are fully responsible for all charges incurred in a medical emergency.

RELEASE WAIVER

I hereby grant permission to Caring Days Adult Day Care Center to release/receive information and records including behavioral and medical reports on:
Name of Client/Patient: _____
Date of Birth: _____ Gender: _____
From (list doctors):
_____
_____
_____
Caregiver:_____
Address:_____Phone Numbers:_____
Signature: _____Date: _____

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PUBLICITY RELEASE

In order to let the public know about our program, there frequently are magazine, newspaper and television stories about our day care. We also have displays at many events including senior days, churches, civic club meetings, and health fairs. Using pictures of clients and events at the Center makes our program more real. The confidentiality of our clients is important to us so we only use pictures if the family gives us permission. It does not affect whether a person is admitted to our program.

I, _____ (caregiver), give permission for _____ to be photographed or filmed for television, newspaper and other promotional uses for Caring Days Adult Day Care. Pictures and videos will be used to inform the public of our program, to educate volunteers and other interested persons, and to keep a record of events at the Center.

Signature: _____Date: _____

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CONDITIONS OF ADMISSIONS

Client Name: _____

1. Admission: Acceptance to the Caring Days program will require a signed referral from a medical doctor and the completed application form. The application will include a medical release form; a media release form and emergency data including insurance information.
2. Arrival and Departure: Caregivers are responsible for getting clients into and out of the Center. If someone other than the Caregiver will be picking up the client, their name must be listed on the application or the workers at the Center need to be informed.
3. Personal Valuables: Caregivers are asked not to allow clients to bring anything of value to Caring Days. Clients do not need money for any activities. Expensive jewelry is greatly discouraged. Caring Days will not be liable for loss or damage to any personal property.
4. Distribution of Medication: Caring Days is not a medical facility but it is understood that many of our clients will require medication during the day. All prescription medicine should come from the client's medical doctor and should clearly indicate the amounts of each medication, times to be administered, and any possible side-effects that may occur.
5. Billing Procedures: Statements will be sent to the Caregivers at the end of each month. Payment is due within 10 days of receipt of the bill. There will be a monthly late fee of $25 on overdue accounts and a $25 fee for returned checks. Checks should be made to Caring Days. Caregivers who fail to settle their account within 10 days of the second notice will be advised in writing that the client is discharged from the program and the matter referred to our attorney for collection.
6. Statement of Financial Responsibility: Unless otherwise determined, I unconditionally guarantee payment in full to Caring Days, A Program of Caring Congregations, Incorporated, for all services rendered to the client. As Caregiver, I will be responsible for all costs of emergency medical care required by the client. I waive any claim of exemptions as to personal property under any applicable law and agree to pay all costs of collection. I agree to pay reasonable attorney fees in the event all or any portion of the bill is unpaid and is referred to Caring Days for collection.

_____
_____Caregiver Signature
Date

CARING CONGREGATIONS, INC.

ADMISSION, ATTENDANCE, LATE PICK-UP POLICY AND DISCHARGE
The following policies will be used to determine eligibility.

Admission: Individuals will be accepted into the program with evidence of the following:

- Physicians referral
- Diagnosis of dementia (Alzheimer's or other memory disorders)
- Age 18 or above
- Completion of Enrollment Application, Release Waiver, and Emergency Information form Completion of financial Agreement

Exceptions to admission criteria may be made at the discretion of the Executive Director/Director.

Attendance:

At the time of admission, an attendance schedule will be established for the client. The caregiver and the Director must mutually agree to any changes to that schedule. The Director will be advised when the client plans to be absent for an extended period of time such as for a family vacation.

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Late Pick-Up Policy

The Caring Days staff works very hard each day to provide a safe, stimulating, and loving environment for our clients. Many staff members have evening commitments; families and caregivers who arrive late often interfere with these plans. Client pick-ups after 5:30pm will result in a late fee* of $20.00 for any 10 minute increments beyond our hours of services. After 3 occurrences, we reserve the right to discontinue service.

*The Caring Days Administration will consider special circumstances including traffic due to trains prior to assessing late charges and may waive all or part of such late charges in the exercise of its sole discretion. No waiver of late charges operates as a waiver for any future late charges regardless of circumstances.

Discharge:
The following would preclude participation in the program:

- Requires continuous one-on-one supervision by Center staff
- Requires restraint for protection of self and others
- Medical needs exceed the capabilities of Center staff
- Sexual or social behavior that is inappropriate and interferes with daily activities
- Diseases that are contagious by casual contact
- Failure to pay for care after the second notice
- Three unscheduled, unexcused absences within a 60 day period
- Justifiable reasons determined by and at the discretion of the Executive Director

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PHYSICIAN'S REFERRAL:

Patient Name:

_____

Date of Birth:

_____

Has the patient been diagnosed with some form of dementia?

_____

Check the type of dementia:

_____ Alzheimer's
_____Multi-infarct
_____Combination of Alzheimer's/Multi-infarct
_____Parkinson's
_____Cancer
_____Huntington's
_____Pick's Disease
_____Other _____

Date of last complete physical examination:

_____

Do you feel that this patient would benefit from a day care program?

_____

Are there any behavioral problems that we need to be aware of at the Center?

_____

If yes, please describe:

Physician's Signature_____
Physician's Printed _____Phone_____

Please fax completed form to 205.752.6841

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