Adult Day Health – Durham Center for Senior Life
Application Packet Instructions

Please follow the following steps prior to submitting your information:

- Caregivers complete: **Section I -** ***Application for Enrollment***
  Section II - ***Participant Profile***
  Section V - ***Permission Forms***

- Applicant or Authorized Representative review and sign:
  Section III - ***Notice of Privacy Practices***

- Separate Document: Applicant's physician complete:
  Section IV - ***Medical Examination Report***

Return all five sections by mail or in person to:

Director, Adult Day Health - Durham Center for Senior Life

406 Rigsbee Avenue Suite 102

Durham, NC 27701

When we have received the completed packet, we will call to schedule an Intake Assessment with the caregiver(s) and the applicant.

Section I - *Application for Enrollment*

Applicant's Full Name _____ Birth date _____Gender _____

Address _____- City _____ Zip _____

Telephone _____ Social Security Number:_____

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? _____

Marital Status: Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced ☐

Present Living Arrangements: With Relatives ☐ With Non-relatives ☐ Alone in Home ☐ Alone in Single Room ☐

Presently Living With: _____ Relationship: _____

If employed, where: _____ Business Phone: _____

Home Address _____City _____ Zip _____

Home Phone: _____

Primary Caregiver: _____ Relationship to applicant: _____

Caregiver's Email 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, City, Zip Telephone Number

(2) _____ _____ _____
Name Relationship to Applicant

_____ _____
Address, City, Zip Telephone Number

Name of Physician: _____ Telephone: _____

Name of Dentist: _____ Telephone: _____

Hospital of Preference: _____

SERVICES REQUESTED:

How many days of week will your loved one attend? _____

Estimated arrival and departure times on an average day: _____

Transportation will be provided by: ☐ Relative/Friend Name:_____

☐ Data Access

☐ Other

Does participant have special dietary needs? _____

Will participant need our Shower Service? IF so, how many times a week? ($15 per shower)

_____

Will staff need to monitor or administer medications at prescribed times?

_____

BILLING INFORMATION:

Participation in this program will be paid for by: ☐ Myself ☐ Relative Name:_____

☐ Department of Social Services or VA

_____
Authorizing Worker's Name /phone #

☐ Other: _____

If paying privately, please indicate billing name and address below:

Name:_____

Address:_____

City/State/Zip:_____

Acknowledgement of Policies and Procedures:

The program's policies and fees have been explained to me and I have received a copy of the policy statement, including participant rights and advanced directives policy. I understand that I am responsible for any charges not covered or authorized by third party payer.

_____ _____

Responsible Party Signature Date

Who may we thank for telling you about our program? (list name, address, phone# if known*)*

_____

_____

RELEASES for: _____
Participant

EMERGENCY CARE

If emergency care becomes necessary, I give permission for any treatment the physician deems necessary. I understand that the program will secure emergency services through the 911 system. Information on file regarding Living wills, Health Care Power of Attorney, etc. will be made available
to emergency personnel. CPR will be initiated unless a properly certified "no code" document is on
file in the program.

_____ _____
Responsible Party Signature Date

NEWSLETTER PARTICIPATION

I give my permission for general information volunteered by me (or my family member) to be used in the Durham Center for Senior Life website, calendar, and/or newsletter. I understand that these will be distributed in the community or to family members of participants for the purposes of information and public relations regarding the Adult Day Health program at the Durham Center for Senior Life (DCSL).

_____ _____
Responsible Party Signature Date

PERMISSION FOR PHOTOGRAPHS/VIDEOTAPING

I authorize the use of photographs taken of me (or my family member) during program activities to be used for the purposes of identification, information, and public relations regarding the Adult Day Health program at DCSL. I understand that the participant's verbal consent will be requested before the pictures are taken or videotaping is initiated. Photographs may also be used on the DCSL website.

_____ _____
Responsible Party Signature Date

PERMISSION FOR AUDIOTAPING

I authorize videotaping of me (or my family member) during program activities to be used for the purposes of information and public relations regarding the Adult Day Health program at DCSL. I understand that the participant's verbal consent will be requested before audiotaping is initiated.

_____ _____
Responsible Party Signature Date

MEDICATION AUTHORIZATION

I hereby authorize the personnel of Adult Day Health to administer the medicines listed below. In doing so , I release Durham Center for Senior Life, its officers, staff, and personnel from any and all liability that might arise as a result of said medication being administered to (participant name) _____, and hereby waive any action which I may have as a result of the medication being administered. I also understand that it is my responsibility to notify the Health Care Coordinator or Director of any changes regarding these medications.

Please note that ALL medications and over-the-counter medications MUST be in a pharmacy labeled bottle with the prescribing Doctor's Name, Medication Name, and Dosage Information in order for them to be stored or administered at the program.

Medication	Dose	Frequency

_____ _____

Responsible Party Signature Date

ROUTINE STANDING ORDERS

MYLANTA – 15 TO 30 CC; every 4 hours PRN indigestion

TUMS – Chew 1 to 2 tablets; PRN gas or indigestion

TYLENOL TABLET 325 mg. – 1 to 2 tabs every 4 hours PRN pain

TYLENOL TABLET 500 mg. – 1 to 2 tabs every 4 hours PRN pain

ROBITUSSIN – 1 to 2 teaspoonfuls every 4 to 5 hours PRN cough

ANTIBIOTIC OINTMENT – Apply thin film to affected skin tear/abrasion PRN (area may be first cleaned with peroxide, normal saline or betadine)

ACCUCHECK – blood sugar as directed by physician and or PRN for s/s of Hyperglycemia

I understand that these may be administered to _____
Participant

_____ _____
Responsible Party Signature Date

Note: Adult Day Health keeps Tylenol on hand. Please supply the other items that may be needed.

Section II - *Participant Profile*

Full Name: _____ Nickname: _____

DOB: _____ Birthplace: _____Places Lived:_____

Educational Level: _____

Primary Language: _____

Able to read? _____Able to write?_____ Right handed or Left Handed **(Circle one)**

Religious Affiliation:_____

Former Occupation(s):_____

_____

Professional Affiliations, Honors, Clubs, Organizations: _____

_____

Military Service (dates, branch, etc.):_____

Retirement (How long ago? Adjustment?): _____

Favorite Foods: _____

FAMILY PROFILE

Marital Status:Married ____ Divorced ____ Single____ Widowed ____ Date of Death _____

Name of Spouse: _____ Years Married: _____

Number of Children _____ List names and current city of residence

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Number of Grandchildren/Great Grandchildren: ____ List names & ages:

_____

_____

Significant Losses (Death of spouse, child, friend, job, etc.): _____

_____

PAST and CURRENT INTERESTS

Activity	Current Interest/Strength?	Past Interest/Strength?
Arts/Crafts (ceramics, painting, drawing, wood working)		
Knitting/needlework/sewing		
Singing (choir, concerts)		
Playing a musical instrument (what instrument?)		
Drama / Acting		
Animals/Pets		
Children		
Sports (which sports?)		
Games (which games?)		
Exercising/ Physical Activity		
Reminiscing		
Cooking/ Baking		
Gardening		
Household chores (which ones)		
Reading/Writing/Poetry		
Outings (travel, movies, parties, dancing, museums)		
Volunteering		
Other (please specify)		

Current Limitations in activities (Physical Limits, Psychological, Attention Span): _____

_____

Special Assistance needed:(i.e. large print type): _____

_____

Other info you would like to share with our staff: _____

_____

WELL-BEING:

Well-being is the path to a life worth living. Well-being transcends illness, functional ability, and cognitive ability. The 7 categories of well-being represent universal human needs. This simple framework of thoughtful questions will help us identify the needs of those we care for. Please answer the following with your loved one, to the best of your/their ability:

How does your loved one recognize or describe themselves or their **IDENTITY?** (sense of self)
In what ways does your loved one wish to **GROW**? (development; enrichment; learn; evolve)
In what ways does your loved one express the need for their **AUTONOMY***?* (self-determination; choice; freedom)
How is your loved one's sense of **SECURITY***?* Are they anxious about anything in particular? What is important to them to feel safe?
How does your loved one **CONNECT** to the world around them? (Are they connected to time, place, and nature)
What brings **MEANING** to your loved one's life? *(*significance; heart; hope; value; purpose; sacredness)
What brings your loved one **JOY** *(*happiness; pleasure; delight; contentment)

Section III - *Notice of Privacy Practices*

Notice of Privacy Practices
Durham Center for Senior Life/Adult Day Health

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully and indicate your receipt of this information on the acknowledgement form.

Our Responsibilities

Durham Center for Senior Life/Adult Day Health is committed to and obligated to protect the privacy of your health information that may also identify you. This health information includes health care services that are provided to you, including general health, mental health and/or developmental disability services, payment for those health care services, or other health care operations provided on your behalf.

This notice describes the ways we may share your past, present and future health information. We may use or disclose this information only as described in this notice. We do, however, reserve the right to change our privacy practices and the terms of this notice, and to make the new notice provisions effective for all health information that we maintain. This information will be available in the adult day services office and updated copies will be made available.

If at any time, you have questions or concerns about the information in this notice or about are agency's privacy policies, procedures or practices, you may contact the Executive Director of Durham Center for Senior Life at (919) 688-8247, or in writing at 406 Rigsbee Ave., Durham, NC 27701.

Use And Disclosure of Health Information Without Authorization

Provision of Services and/or Treatment
Durham Center for Senior Life/Adult Day Health may use or disclose your health information as needed in order to provide, coordinate, or manage your health care and related services. This includes sharing your health information with other health care providers, both within and outside this agency, when we need to coordinate and manage your health care, or when necessary to protect the public health.

Example: We may share your health information with doctors, emergency medical providers, and hospital health providers in the event of a medical emergency that requires transport to a hospital emergency room for evaluation or treatment. You are requested to sign a release for provision of emergency care as a part of our admission process and we may share health information as a need in such situations.

Example: We may contact Public Health if you returned a positive test for Tuberculosis or similar communicable disease and if you had contact with others who might also become infected. This disclosure is required and protected by law if necessary to protect public health.

Example: We may share pertinent health information in the event you transfer or plan to transfer for care or services to another provider, agency, or facility. This is to assure continued coordination of health services that you may receive once you are discharged from our care.

Durham Center for Senior Life may use and give your health information to other staff, other agency employees, and/or health plans that are designated to bill and collect payment for the health care services received by you. We may share information with others to determine coverage status prior to service provision. We will share information with agencies or providers that participate in the preparation, authorization or management of accounts in order to ensure payment for services provided. We may share your health information with agents of your insurance company or health plan (should such coverage apply) to confirm services that were provided to you. We may also share your health information with those who review services to make certain that appropriate services and treatment were provided.

Example: The services provided to you may be shared with the appropriate funding source or guarantor so that they may pay all or a portion of your bill. The funding source or guarantor determines the information required for this process. Business

associate contracts or memorandums of understanding may be negotiated between providers and these funding sources or guarantors in order to accomplish this process.

Other Health Care Operations

Durham Center for Senior Life/Adult Day Services may disclose your health information in performing a variety of business activities related to health care operations. These health care operations may allow us to improve or assure the quality of care we provide to you and to our other clients and may help us to reduce costs. In some cases, there may be benefits or protections for specific individuals.

Example: We may provide training programs or educational opportunities for students, trainees, health care providers or non-health care providers that allow these individuals to enhance their knowledge or skills. These individuals will be informed of confidentiality policies of this facility and indicate acceptance and adherence to those policies prior to beginning training. Any information they may gain as a result of their association with us will be governed by their acceptance of those policies. Any research initiatives conducted by our agency will be used to improve services or benefits and identifying health information will not be included in public reporting. Individuals assisting with the collection of such data will be provided confidentiality agreements as outlined above.

Example: We may provide information to professional organizations that evaluate, certify, or license health care providers, staff, or facilities in a particular field or specialty.

Example: We may share information with other agencies that have responsibilities for quality, safety or compliance with service or health care standards. These include, but are not limited to, the Department of Social Services, the Division of Aging, Area Agency on Aging, Department of Public Health, and the Office of Fire Safety/Emergency Management.

Example: We may share information necessary for investigation of suspected abuse, neglect, or violence to appropriate investigative personnel.

Example: We may share information requested by the legal system in determination of competency of individuals for whom we provide services.

Use and Disclosure of Health Information That Requires Your Authorization

Durham Center for Senior Life will not use or disclose your health information without your authorization except as specified above or when required by State or Federal law. For all other uses or disclosures, we will ask you (or your responsible family member) to sign a written authorization for such sharing or disclosure. This release will indicate the information requested, the party requesting the information, and the purpose of the request. You may revoke any written authorizations granted by contacting our Privacy Officer. Your authorization will be considered invalid from that point in time. However, any actions taken on the authorizations prior to the time of cancellation are legal and binding.

Your Rights Regarding Your Health Information

You have the following rights regarding your health information as created and maintained by Durham Center for Senior Life/Adult Day Health Services:

- Right to receive a copy of this notice. You will receive a copy of this notice in our admission packet. Additional copies are available in the program office.

- Right to request different ways to communicate with you. You may request to be contacted at a different location or by a different method. For example, you may request that all communications be directed to your work address rather than your home address. We will agree to your request as long as it is reasonable to do so. Your request should be made in writing to the ADH Director.

- Right to request to see and copy your health information. You have the right to request to see and receive a copy of your health information record, billing record or other records used to make decisions about you or your care. Your request must be made in writing to our Privacy Officer. You may be charged a fee to cover copying and/or postage for such a request. A summary of health information may be provided if agreed upon in advance.

  Your request may be denied under certain circumstances and if we do deny your request, we will do so in writing along with an explanation for cause and for any rights of appeal that may be available to you.

- Right to request amendment of your health information. You have the right to request changes in your health information records. You may submit the request in writing to the ADH Director along with an explanation of the reasons for the request. We must respond to your request within 60 days of receiving it.

  If we deny your request to change your health information, we will tell you in writing the reasons for the denial and your rights to give a written statement disagreeing with the denial. If we accept your request to change your health information, we will make reasonable efforts to inform others who need the changes.

- Right to request a listing of disclosures we have made. You have the right to request and receive a written list of disclosures of your health information, made after April 14, 2003 and to whom the disclosures were made. This agency is not required to include on the list disclosures for the following: for your treatment, for billing and collection of payment for your treatment, for our health care operations, for disclosures requested and authorized by you, and for other exceptions as allowed by law.

- Right to request restrictions on uses and disclosures of your health information. You have the right to request that we limit our use and disclosure of your health information for treatment, payment, and health care options. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or friend.

  We are not required to agree to such requests. However, if we do agree, we must follow the agreed upon restriction until such time as the restriction is cancelled by either party.

Acknowledgement of Receipt of Privacy Practices

I have received Adult Day Health's Notice of Privacy Practices describing this agency's method for protecting the privacy of my identifiable health information used in providing services to me.

I have reviewed this document and have had the opportunity to ask for clarification of anything that I do not understand.

_____ _____

Applicant signature (or Authorized Representative) Date

This signed and dated receipt will be retained by Adult Day Health.

Section V – Permission Forms

CAREGIVER'S PERMISSION FOR PARTICIPANT PICK-UP

I, _____, Caregiver for _____, give permission for the following additional person(s) to pick-up my loved one from the Adult Day Health on my behalf.

Name	Relationship to participant
1)_____	
2)_____	
3)_____	
4)_____	
5)_____	

_____ _____

Responsible Party Signature Date

Please note:
We will not release your loved one to anyone who is not listed above, with the exception of Access Van riders and anyone in need of emergency medical care involving EMS transport. You may update this form as needed, in person at our office. People listed above must show a valid form of picture identification to our staff before we will release the participant into their care. This policy is to ensure the safety and well-being of our participants.

CAREGIVER'S PERMISSION FOR VISITATION

I, _____, Caregiver for _____, give permission for the following person(s) to visit my loved one at the Adult Day Health Program.

Name	Relationship to participant
1)_____	
2)_____	
3)_____	

_____ _____

Responsible Party Signature Date

Please Note:
Visitation can be disruptive and confusing to your loved one. However, if you have someone who wants to visit, please let us know ahead of time. The best time for visits are before 11 a.m. or after 3 p.m. We will do our best to accommodate your request.

Section IV -*Medical Examination Report*

ADULT DAY HEALTH
MEDICAL EXAMINATION REPORT

Name_____ DOB _____

Most Recent Date Seen by Doctor prior to this visit? _____

The above named person has applied for, or is enrolled in our adult day health care program. Please complete this form in detail. Your careful examination and written recommendations will help to ensure that the applicant is provided appropriate care and services and will provide a current medical history in case of emergency. Information reported on this form is considered confidential and will be released only with the applicant's written authorization.

1. Does the applicant have any of the following diseases or conditions? If so, please indicate whether or not the condition requires any special attention or restricts normal activities.

CURRENT DISEASE/ CHRONIC CONDITION	YES	Special Attention Required?	Restriction on Activities?
ANEMIA			
ARTHRITIS			
ASTHMA			
BLINDNESS			
CEREBRAL PALSY			
DEMENTIA – *List type: Vascular, Alzheimer's, Lewy Body, other?*			
DIABETES			
DIARRHEA			
EMPHYSEMA			
EPILEPSY			
FAINTING SPELLS			
GASTRO-INTESTINAL PROB.			
HEART TROUBLE			
HEARING PROBLEMS			
HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
DOWN'S SYNDROME			
SKIN DISORDERS			
STROKE / PARALYSIS			
TUBERCULOSIS			*TEST RESULTS?
URINARY TRACT PROBLEMS			
MOBILITY ISSUES			
INTELLECTUAL DISABILITY			
OTHER?			
OTHER?			

2. List all allergies or reactions to medications? _____

_____

3. Is client receiving any on-going medical treatments? If so, please explain.

_____

_____

4. Does this person have any psychiatric problems? ____NO ____ YES - **If yes, please provide information re: type, severity, and treatment needs:**

_____

_____

5. Does this person require constant supervision to make sure he/she does not do harm to self, others, or property? _____ NO _____ YES

6. Is this person at risk for wandering? _____ NO _____ YES

7. Does this person require any restrictions on physical activities such as walking, chair exercises, etc, - based on a medical condition? _____ NO _____ YES - **If yes, please specify:**

_____

8. Please list all medications the person is now taking*, or attach a separate sheet*, listing ***dosages*** *and* ***times*** medications are to be taken:

1)_____ 6)_____

2)_____ 7)_____

3)_____ 8)_____

4)_____ 9)_____

5)_____ 10)_____

9. Special diet? _____ NO _____ YES - **If yes, please describe or attach a copy:**

_____

10. Any other comments?

_____

_____

I certify that I have examined this person & their health history and find him/her able to participate in an adult day health care program.

Date: Signature:_____

Printed Name:_____

Licensed Physician or P.A.

Office Address/Phone/Fax: