Aging Care Matters

Aging Care Matters Adult Day Center

Application

ACM
Aging Care Matters
Adult Day Center

Application For Enrollment

Participant's Name: _____

Application

Applicant's Full Name: _____ **Phone:** _____

Address: _____

DOB: _____ **Sex:** _____

Allergies: _____

INFORMATION ABOUT APPLICANT

Why are you interested in 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: _____

Living with Whom: _____ **Relationship:** _____

Nearest Responsible Relative: _____ **Relationship:** _____

Requested Schedule.
Mark as 1st/2nd and 3rd Choice

☐ 5 Days Mon-Fri ☐ 3 Days M/W/F ☐ 2 days Tues/Th

Application For Enrollment

Participant's Name: _____

EMERGENCY CARE INFORMATION

List the names of <u>two additional</u> persons who may be contacted in case of emergency:

(1)

_____ **Name** _____ **Relationship to Applicant**

_____ **Address** _____ **Phone Number**

_____ **Name** _____ **Relationship to Applicant**

(2)

_____ **Address** _____ **Phone Number**

Name of Primary Physician: _____ **Phone Number**

Name of Dentist: _____ **Phone Number**

Transportation will be provided by: _____
Name and Phone Number

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 ☐ Hearing Aid ☐ Dentures

☐ Eyeglasses (Contacts) ☐ Other, please list: _____

_____

Participant's Name: _____

Application For Enrollment (cont.)

ADVANCE DIRECTIVE NOTIFICATION

☐ **My family member does not require a POA, may make his/her own medical or other decisions, and may sign for his/herself legally.**

☐ **My family member has an activated Power of Attorney or legal guardian.**

Name of POA/Guardian: _____ Phone Number: _____

☐ **My family member has an advance directive.**

☐ I will provide the day center with a copy.

☐ **My family member does not have an advance directive**

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

☐ My family member does not want an advance directive.

☐ **My family member has a DNR order**

☐ I will provide the day center with an original copy.

Aging Care Matters Adult Day Center's policies have been explained to me and I have been given a copy of them and agree to abide by them.

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

Applicant Signature: _____ **Date:** _____

Responsible Party Signature: _____ **Date:** _____

Authorization

Participant's Name: _____

Authorization to Release and Obtain Medical Information to AGING CARE MATTERS, LLC

This form is used to release and/or obtain your protected heal information as required by federal and state privacy laws. Your authorization allows the staff of **Aging Care Matter, LLC to release and/or obtain** your protected health information to/from a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing. Revoking this authorization will not affect any action taken prior to the receipt of your written request.

Client's Name: _____

Address: _____

Date of Birth: _____ Telephone Number: _____

Signature: _____ Relationship: _____

I authorize release of my protected health information as described below:

- I authorize the staff of Aging Care Matters, LLC to obtain and review my medical records from my physician of record, medical practitioner, hospital, clinic, or other medical or medically related facilities, insurance company, or other organization, institution, or person that has any of my health information if needed in order to provide to me and on my behalf.
- I authorize the staff of Aging Care Matters, LLC to share their records with my physician of record, medical practitioner, hospital clinic, or other medical or medically related facility, insurance company, or other organization, institution, or person that has any of my health information if needed in order to provide to me and on my behalf.
- I authorize the staff of Aging Care Matters, LLC to contact individuals indicated as my emergency contact individual(s) in the event of an emergency or significant change in my health status.
- I authorize the staff of Aging Care Matters, LLC to attend any care plan meeting or physician appointments on my behalf.

Purpose of Release: To Provide services to me or on my behalf.

Recipient: Aging Care Matters, LLC

Carla Payne

Carla Payne, Owner Aging Care Matters, LLC
Carla@AgingCareMatters.com

Expiration:
This authorization will expire when services from Aging Care Matters, LLC are terminated.

Member Profile

Participant's Name: _____

Name: _____ Nickname: _____ DOB _____

Former Occupation(s): _____

_____

Religious Preference: _____

Completed Level of Education: _____ School/University: _____

_____

Activities of Enjoyment (Current or Past) NOTES

Music _____

Singing _____

Playing Musical Instrument _____

Animals/Pets _____

Children _____

Sports _____

Games _____

Exercising/ Physical Activity _____

Reminiscing _____

History/Science _____

Knitting/Needlework/Sewing _____

Art/ Drawing/Painting _____

Gardening _____

Household Chores/Repair _____

Other: _____

_____

_____

_____

Member Profile

Participant's Name: _____

Family History

Number of Siblings: _____. Names: _____

_____

Mother's Name: _____

Father's Name: _____

Spouse(s) Please indicate names and whether living or date of death: _____

_____

Children Please indicate name, order and whether living or date of death: _____

_____

Grandchildren/ Great-grandchildren's Names: _____

_____

_____

_____

Places Lived: _____

_____

_____

Other Stories/Events you would like to share: _____

_____

_____

_____

_____

_____

Completed By: _____ Date: _____

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Completed by Physician/PA/NA

The individual listed below has applied to participate in the Aging Care Matters Adult Day Center. 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.

Patients Name: _____ **Birth Date:** _____

Most Recent Date Seen by a Doctor: _____

Blood Pressure: _____ **Pulse/Respiration:** _____ / _____ **Weight:** _____

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

☐ **Is a special diet or other special regimen required for this patient?**

☐ Yes; If yes, please attach or describe: ☐ No

_____

_____

☐ **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.**

_____

_____

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.

_____ _____
M.D., P.A. or Nurse Practitioner **Date**

_____ _____
Address **City**

(____)_____
Phone Number

Participant's Name: _____

Aging Care Matters Adult Day Center
2022-23 Monthly Rate Schedule

The payment schedule is based on the projected days of enrollment and represent days that a space has been reserved for the participant at the center. Holidays have already been taken into consideration. The participant will be billed at a rate of $112 per day

5 days per week = $2240 per Month
3 days per week = $1344 per Month
2 days per week = $896 per Month

Aging Care Matters will submit monthly statements to responsible party and assist with Long Term Care Insurance reimbursement paperwork.

I desire to enroll with Aging Care Matters Adult Day Center for:

☐ 5 days per week = $2240 per Month
☐ 3 days per week = $1344 per Month
☐ 2 days per week = $896 per Month

Representative Signature: _____

Date: _____