Aging Care Matters Adult Day Center

Application

Nonrefundable Application Fee
$100 public/ $50 for ACM current clients

v.01312023

Application For Enrollment

Nonrefundable Application Fee
$100 public/ $50 for ACM current clients

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:** _____

Potential 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**

(2) _____ **Name** _____ **Relationship to Applicant**

_____ **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: _____

_____

Potential Participant's Name: _____

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:** _____

Aging Care Matters, LLC
DBA Aging Care
Adult Day Center

Authorization To Release Information

Authorization to Release and Obtain Medical Information
to AGING CARE MATTERS, LLC DBA Aging Care Adult Day Center

This form is used to release and/or obtain your protected health information as required by federal and state privacy laws. Your authorization allows the staff of **Aging Care Matter, LLC DBA Aging Care Adult Day Center 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.

Participant's Name: _____

Address: _____

Date of Birth: _____ Phone Number:: _____

Signature: _____

Relationship to Participant: _____

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

- I authorize Aging Care Matters, LLC DBA Adult Day Center 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 Aging Care Matters, LLC DBA Adult Day Center 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 Aging Care Matters, LLC DBA Adult Day Center 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 Aging Care Matters, LLC DBA Adult Day Center to attend any emergency care, care plan meeting or physician appointments on my behalf if requested by myself or my Health Power of Attorney.

Expiration: This authorization will expire when services from Aging Care Matters, LLC or the Adult Day Center are terminated.

Recipient: Aging Care Matters, LLC

Carla Payne

Carla Payne, CMC / Owner Aging Care Matters, LLC & DBA Aging Care Adult Day Center
Carla@AgingCareMatters.com
919-525-6464

Member Profile

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: _____

_____

_____

_____

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: _____

Aging Care Matters, LLC
DBA Aging Care
Adult Day Center

Completed by Physician/PA/NA

The individual listed has applied to participate in our Aging Care Matters, LLC Adult Day Center. The following medical information must be completed by a physician before they are approved for participation.

Patients Name: _____ Birth Date: _____

Most Recent Date Seen by Doctor: _____ Blood Pressure: _____ Pulse/Respiration: _____/_____ Weight: _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Does this person require constant supervision to make sure harm is not done to self, others or property? Yes / No Will this person wander 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 ☐

May this person be given Tylenol? Yes ☐ No ☐ Tums? Yes ☐ No ☐

Is a special diet or other special regimen required for this person? Yes ☐ No ☐

If YES, Please describe and attach diet instructions to be followed: _____

_____

_____

From your knowledge please comment on any physical, mental or emotional condition needing further explanation or that may affect other participants in the Adult Day Center program: _____

_____

_____

_____

_____

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

_____ Date: _____

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

_____ _____ _____

Address City Zip Code

_____ _____

Phone Number Fax Number

v.01312023

Forms to Return to Program Manager

1) Late Pick Up Notice Signature Form ☐
2) Authorization for Publication Form ☐
3) Authorization for Photography Form ☐
4) Program Policies Participant Signature Form ☐
5) Monthly Rate Schedule ☐
6) Responsible Party/Emergency Contact Information ☐
7) Medication List ☐
8) Medication Policy ☐
9) Consent for Services Form ☐
10) Application for Enrollment pages 1 - 3 ☐
11) Authorization to Release Information Form ☐
12) Member Profile pages 1-2 ☐
13) Medical Examination (completed by physician, PA or NP) ☐