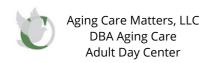
Aging Care Matters

Aging Care Matters Adult Day Center

Application

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



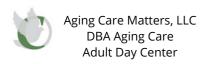
<u>Application</u>

Application For Enrollment

page 1

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

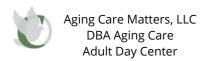
Applicant's Full Name:	Phone:
Address:	
DOB: Sex:	
Allergies:	
INFORMATION ABOUT APPLICANT	
Why are you interested in this program?	
Have you had previous experience in a day pro	ogram? Yes No
If yes, where and when?	
Marital Status: Married Single	Separated Widowed Divorced
Present Living Arrangements:	
Living with Whom:	Relationship:
Nearest Responsible Relative:	Relationship:



Application for Enrollment

page 2

		Potential Participant's Name:
EM	ERGENCY CARE INFORMA	TION
_ist	— the names of <u>two additional</u> រុ	ersons who may be contacted in case of emergency:
(1)		
(1)	Name	Relationship to Applicant
	Address	Phone Number
(2)	Name	Relationship to Applicant
	Address	Phone Number
Nan	ne of Primary Physician:	Phone Number
Nan	ne of Dentist:	Phone Number
Γrai	nsportation will be provided by:	Name and Phone Number
Sno	rial diatary poods if any	
spe	cial dietary needs, if any:	
* ^ +	tach a copy of the doctor's orders	if on a thorangutic dist
"Al	tach a copy of the doctor's orders	ii oii a tilerapeutic diet
Sup	portive devices used by applicant:	Cane Walker Hearing Aid Dentures
		Eyeglasses (Contacts) Other, please list:



Application for Enrollment

Potential Participant's Name: _____

page 3

ADVANCE DIRECTIVE NOTIFICATION ——	
My family member does not require a POA, may make for his/herself legally.	e his/her own medical or other decisions, and may sign
My family member has an activated Power of Attorney	y 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	e.
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 copy of them and agree to abide by them.	ve been explained to me and I have been given a
If emergency medical care becomes necessary, <u>I g</u> deems necessary.	ive permission for any treatment the physician
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.

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Carla Payne

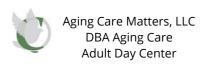
Carla Payne, CMC / Owner Aging Care Matters, LLC & DBA Aging Care Adult Day Center Carla@AgingCareMatters.com

919-525-6464

A sing Care Matters, LLC / Adult Day Center

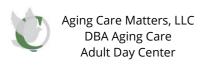
Aging Care Matters, LLC / Adult Day Center 3309 Rogers Road, Suite 117, Wake Forest, NC 27587 919-525-6464 / Admin@AgingCareMatters.com www.AgingCareMatters.com

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Member Profile

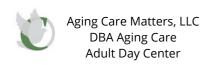
Name:	Nickname:	DOB
Former Occupation(s):		
Religious Preference:		
Completed Level of Education:		
Activities of Enjoyment (Current or Past)	<u>NOTES</u>	
Music		·
Singing		
Playing Musical Instrument		
Animals/Pets		
Children		
Sports		
Games		•
Exercising/ Physical Activity		
Reminiscing		
History/Science		
Knitting/Needlework/Sewing		
Art/ Drawing/Painting		
Gardening		
Household Chores/Repair		
Other:		



Member Profile

page 2

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:
other stories/Events you would like to share.
·
Completed By: Date:



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:	Seconda	ry Diagnosis:	
Does this person require constant supervis	sion to make sure harm is	s not done to self, others	or property? Yes / Will
this person wander if not closely attended	? Yes No		
Can this person do light exercises from a	sitting position, such as l	eg 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 r If YES, Please describe and attach diet in	•		
From your knowledge please comment or may affect other participants in the Adult	Day Center program:		
I certify I have today reviewed the heal participate in an adult day care activity	•	d this person and find t	they are physically able to Date:
M.D., P.A. or Nurse Practitioner Signatur	re		Date
Address		City	Zip Code
Phone Number		Fax Number	

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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)