

Caring Days
A Day Program for Adults with Memory
Disorders
P.O. Box 3049
Tuscaloosa, AL 35403
205.752.6840

ENROLLMENT APPLICATION:

Date: _____ REFERRAL SOURCE: _____

Days Needed: _____ Full Days _____ Half Days

___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday

Does the applicant receive: AL Cares ___ VA Services ___ LTC Insurance ___

PERSONAL INFORMATION (ABOUT APPLICANT):

Name: _____

Nickname: _____ Maiden: _____

Street
Address: _____ City, Zip: _____

Sex: _____ Age: _____ Date of Birth: _____

Race: _____ Marital Status: _____ Religious Affiliation: _____

Level of Education: _____ Military Record: _____

Employment History: _____

Applicant Lives With: _____

Primary Caregiver: _____ Relationship to Caregiver: _____

Address if Different from Applicant: _____

Email address: _____

How many people live in the home? _____ Phone: _____ Cell: _____

Employment: _____ Work Phone: _____

Other Caregivers: _____

Names of Children	Address	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____

Names of Siblings	Address	Phone#
_____	_____	_____
_____	_____	_____

Names of Close Friends	Address	Phone#
_____	_____	_____
_____	_____	_____

GENERAL INFORMATION:

1. Is the applicant able to self-feed? _____ If no, what assistance is needed? _____

2. Is the applicant able to self toilet? _____ If no, what assistance is needed? _____

3. Is the applicant incontinent? _____ If yes, how often? _____
How do you handle incontinence? _____

*If applicant requires incontinence supplies, the family will be required to provide them.

4. Is the applicant able to ambulate independently? _____ If no, what assistance is needed? _____

5. Does the applicant require a special diet?_____ If yes, please

describe:_____

6. Does the applicant experience agitation/hostility?_____

What situations increase agitation/hostility?_____

7. What methods reduce agitation/hostility?_____

8. Does the applicant wander?_____

9. What makes the applicant happy?_____

10. Does the applicant like children?_____ Pets?_____

11. What makes the applicant fearful or sad?_____

12. What hobbies and interests does the applicant have?

13. What are the applicants favorite foods?_____

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

15. Circle all 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

Outside Activities

Housework

Music

Cooking

Gardening

Cooking

Fishing

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

MEDICAL INFORMATION:

Physician Who Diagnosed Dementia

Name: _____ Phone: _____

Address: _____

Primary Care Physician

Name: _____ Phone: _____

Address: _____

Other Physicians Currently Seeing the Applicant

Name: _____ Phone: _____

Name: _____ Phone: _____

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 | Hip Fractured/Replacement |
| Obesity | Osteoporosis | Respiratory problems |
| Seizures | Vision Problems | Weight Loss |
| Other: _____ | | |

Allergies: _____

Dietary Restrictions: _____

Psychiatric Problems: _____

Has the applicant ever been diagnosed with tuberculosis? _____

Has the applicant had a physical in the last 12 months? _____

Current prescription and over the counter medications and dosages: __

Will medication need to be administered during day care hours?_____

Is there any medical problem that would put the applicant at risk in the day care setting?_____

Does the applicant have any medical problems that would put other participants at risk in the day care?_____

What are your expectations for Caring Days?_____

Does the applicant have a living will?_____

Does the applicant have a "no code" or DNR (do not resuscitate) order?_____

*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.

Has someone been legally assigned as guardian for the applicant?_____

Name:_____Phone:_____

Address:_____

EMERGENCY CONTACTS AND INFORMATION:

Name:_____

Address:_____

Home #:_____Work #:_____Cell #:_____

Others we may contact in case of Emergency:

Name:_____Phone #:_____

Physician:_____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: _____

Type of Insurance: _____

Policy Number: _____

Group Number: _____

Other 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: _____ Sex: _____

Social Security Number: _____

From (list doctors):

_____	_____
_____	_____
_____	_____

Caregiver: _____

Address: _____

Phone Numbers: _____

Signature: _____ Date: _____

**CARING DAYS
PUBLICITY RELEASE**

In order to let the public know about our program, there are frequently 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.

Caregiver Signature: _____ Date: _____

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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: _____ Date: _____

Print Name of Physician: _____

Address: _____

Phone: _____

FAX 205.752.6841

CARING CONGREGATIONS, INC ADMISSION, ATTENDANCE, AND DISCHARGE

The following policies will be used to determine eligibility.

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

- Physician referral
- Diagnosis of dementia
- 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.

Attendance:

At the time of admission, an attendance schedule will be established for the client. The caregiver and the Executive Director must mutually agree to any changes to that schedule. Clients are expected to attend when scheduled.

Clients who do not attend as scheduled without notice and/or an acceptable reason, will be charged 50% of the rate for the day. After the second such unscheduled/unexcused absence in 60 days, the caregiver will be advised that this is unacceptable and could cause the client to be discharged from the program.

The Executive Director will be advised when the client plans to be absent for an extended period of time such as for a family vacation. Given adequate notice, the client's slot will be held for up to one week at no charge. Beyond one week, a 50% charge will be assessed to hold the slot.

Occasionally, clients must be absent for extended periods of time because they need more intense care such as in a hospital or nursing home. If it appears that the client will be able to return to the program, the slot will be held at no charge for one week. After one week, the slot can be held indefinitely by paying 50% of the rate. Otherwise, the client will be discharged and placed at the top of the waiting list for re-admission when cleared by his/her physician.

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

CARING DAYS CONDITIONS OF ADMISSION

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: _____