

Caring Together Adult Wellness Center

4415 – 18th Street

Tuscaloosa, Alabama 35401

(205) 345-8638

Enrollment Application:

Date _____ **Referral Source:** _____

Days needed:

___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday

PERSONAL INFORMATION:

Name: _____

Nickname _____

Address _____ Phone _____

Phone _____ Age _____ Date of Birth _____

Sex _____ Race _____ Marital Status _____

Level of Education: _____

Employment History: _____

Applicant lives with: _____

Primary Caregiver _____ Relationship _____

Address if different from applicant _____

Names of Children/Location

Care Information:

1. Is the client 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? _____

4. Is the applicant able to walk independently? _____

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

6. Does the applicant experience agitation?

If yes, what situations cause the agitation? _____

7. Does the applicant wander? _____

8. What makes the applicant happy? _____

9. What are the applicant favorite foods? _____

10. Does the applicant like children? _____ Pets _____

11. What hobbies/interest has the applicant had in the past?

12. What kind of music does the applicant enjoy? _____

Circle all activities that the applicant enjoys:

- | | | | |
|-----------|------------|-------------|--------------|
| Dancing | Walking | Exercising | Reminiscing |
| Reading | Television | Movies | Storytelling |
| Sports | Puzzles | Card Games | Art/Crafts |
| Gardening | Music | Woodworking | Cooking |
| Computer | Games | | |

Please share any other information that would help us provide a rewarding experience for this applicant?

MEDICAL INFORMATION:

Dietary Restriction: _____

Allergies: _____

Current Prescriptions and over-the-counter medications:

Will the applicant need to take any medication while at the Center?

Is there any medical problem that would put this 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? _____

Has someone been legally assigned as guardian for the applicant?

Name: _____ Phone _____
Address _____

Primary Care Physician:

Name: _____ Phone _____
Address: _____

CURRENT MEDICAL PROBLEMS: (Circle all that apply)

- | | | |
|-------------------------------|----------------------|--------------|
| Digestive/Intestinal Problems | Osteoporosis | Obesity |
| Vision Problems | Hearing Problems | Dizzy Spells |
| Diabetes | High Blood Pressure | Seizures |
| Asthma | Arthritis | Cancer |
| Heart Problems | Depression | Alcoholism |
| Hip Fracture/Replacement | Respiratory Problems | Drug Abuse |

Caring Together

Publicity Release

In order to let the public know about our program, there are frequently 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 makes our program more real. The confidentiality of our clients is important to us so we only use pictures if the family gives permission. Your decision does not affect whether a person is admitted to our program.

I _____ (caregiver for Caring Together client) give permission for

To be photographed or filmed for television, newspaper, and other promotional uses for Caring Together Wellness Center. 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 _____

Caring Together Adult Wellness Center

Release Waiver:

I hereby grant permission to Caring Together Adult Wellness Center to release/receive information and records including behavioral and medical reports on:

Name of client: _____

Date of birth: _____ Sex: _____

Social Security Number: _____

From: (list doctors) _____

Caregiver: _____

Address: _____

Phone: _____

Signature: _____

Date: _____

Caring Together Wellness Center

Emergency Information:

Client _____

Who to contact in case of emergency:

Name _____ Phone _____

Address _____

Hospital preference _____

*If you prefer 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 to have us make that decision? _____

Does the applicant have insurance? _____ If yes,

Insurance Company _____

Policy Number _____

Group Number _____

Medicare/ Medicaid Number _____

I give Caring Together permission to seek emergency medical treatment in the case of illness or accident. I understand and agree that I am fully responsible for any charges incurred.

Caregiver Signature _____

Date _____

