Caring Days

ENROLLMENT APPLICATION

Date: _____ Referral Source: _____

APPLICANT INFORMATION

Name: _____

Nickname: _____ SS# _____

Address: _____

Date of Birth _____ Age: _____ Gender: _____

Race: _____ Marital Status: _____ Religious Affiliation: _____

Level of Education: _____ Military Record: _____

Employment History: _____

Applicant Lives With: _____ # in household _____

DAYS NEEDED	Monday	Tuesday	Wednesday	Thursday	Friday
Full Day					
Half Day					

About our program…

Caring Days is a social setting day care and not a medical facility. Our program centers around the social needs of our clients. We have a nurse on staff. She does not do medical procedures but rather observes the clients and communicates with the caregivers and employees. The nurse keeps current medical information on our clients and dispenses medications.

Please do not bring clients who have a fever, severe open wounds, or anything else that would put them or other clients at risk.

943 31st Street East
Tuscaloosa, AL 35403

Phone: 205.752.6840
Fax: 205.752.6841

CAREGIVER INFORMATION

Primary Caregiver: _____

Relationship to Applicant: _____

Address (if different from applicant): _____

Home Phone: _____ Cell Phone: _____

Email Address_____

Employment: _____ Work Phone _____

NAMES OF CHILDREN ADDRESS PHONE #

_____

_____

_____

NAMES OF SIBLINGS PHONE #

_____

_____

GENERAL INFORMATION

Does the applicant need assistance with: ***(please circle)***

Mobility **Toileting* *Feeding* *Special Diet* *Redirecting*

What kinds of activities does the applicant enjoy?

_____

_____

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

_____

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

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MEDICAL INFORMATION

Physician who diagnosed dementia: _____

Other physician/s currently seeing the applicant:

Name: _____Phone: _____

Current medical problems: _____

_____

Does the applicant have any allergies? _____

(ex: food, medicines, skin, etc.)

Has applicant ever been diagnosed with tuberculosis? Yes ____ No ____

Has the applicant had a physical in the last year? Yes ____ No ____

List current prescription and over-the-counter medications and dosages

_____

_____

_____

_____

_____

Will medication be administered during day care hours?

Yes ____ No ____

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

_____

Does the applicant have a DNR (do not resuscitate) order?

Yes ____ No ____

Since Caring Days is not a medical facility, we do not determine when a DNR should go into effect. For medical emergencies we will call 911 and request medical assistance.

Has someone been legally assigned as guardian for the applicant?

Yes ____ No ____

Name _____ Phone _____

Address _____

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CLIENT PICK UP LIST

Name Phone #

_____

_____

_____

_____

_____

EMERGENCY CONTACTS & INFORMATION

Primary Contact _____Cell #_____

Address: _____

Home # _____ Work # _____

Secondary Contact: _____ Phone # _____

Hospital Preference: _____

If the paramedics feel that it would be better to take them to DCH or Northport DCH, they can advise us that if they take them to one hospital, over the other, due to the type of medical problem or the time element, that another medical facility would better suit the needs of the patient.

Insurance: _____ Policy #_____

Caregivers are fully responsible for charges incurred in a medical emergency.

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RELEASE WAIVER

I hereby grant permission to Caring Days Adult Day Care to release/receive information and records including behavioral and medical reports on:

Name of Client/Patient: _____

Date of Birth: _____ Gender: _____

From *(list doctors):* Phone numbers

_____ _____

_____ _____

Caregiver: _____

Address: _____

Signature: _____Date: _____

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PUBLICITY RELEASE

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

Signature: _____ Date: _____

☐ ***Check box if you opt out...***

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CONDITIONS OF ADMISSION

Client Name: _____

Admission: Acceptance to Caring Days will require a signed referral from a medical doctor and the application completed by a caregiver

1. 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.
2. Caregivers are asked not to allow clients to bring anything of value to Caring Days. Clients do not need money and jewelry is easily misplaced. Caring Days will not be liable for loss or damage to any personal property.
3. Caring Days is not a medical facility, but it is understood that many of our clients require medication during the day. All prescriptions should come from the client's medical doctor and clearly indicate the amounts of each medication, times to be administered, and side-effects.
4. Statements will be sent to 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 payable 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.

Caregiver signature _____ Date _____

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ADMISSION, ATTENDANCE, LATE PICK-UP POLICY AND DISCHARGE

Admission: Individuals can be accepted into the program with evidence of:

- Physicians' referral with an appropriate dementia diagnosis
- Completion of Enrollment Application, Release Waiver, and Emergency Information form, and completion of a Financial Agreement

Exceptions to admission criteria may be made by the Executive Director

Attendance:

At the time of admission, an attendance schedule will be established for the client. Changes to that schedule will be approved by the Executive Director.

Late Pick-Up Policy:

Please be on time to pick up our clients. Clients picked-up after 4:30 pm will result in a late fee* of $20.00 for any 10-minute increments beyond our hours of services. After 3 occurrences, we reserve the right to discontinue service.

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**
- **Inappropriate sexual or social behavior**
- **Diseases that are contagious by casual contact**
- **Failure to pay for care after the second notice**

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Patient's Name _____

Date of Birth: _____

Has patient been diagnosed with some form of dementia?

Yes ___ No ___

Check the type of dementia:

_____Alzheimer's

_____Vascular

_____Traumatic Brain Injury

_____Parkinson's

_____Huntington's

_____Pick's Disease

_____Alcoholism related

_____Mild Cognitive Impairment

_____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_____

Print Physician's name_____ Phone_____

Please fax completed form to 205.752.6841

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