



A Day Program
for Adults at

The Life Center

Of Davidson County, Inc.

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Committee

Executive Director

Carolyn Sidwell

601 West
Center Street
Lexington, NC
27292

Phone:

336-249-2155

Fax:

336-249-2374

Email:

Lifecenter

@lexcominc.net

LifeCenterDavidson.com

To the applicant, family member, or responsible person,

Attached is an application for participation in the adult day/adult day health program of The Life Center. The information on this application is confidential and will be used to enable our staff and Quality Assurance Committee members to assess whether The Life Center can provide the level of care requested. Financial information will be used only to determine eligibility for fee assistance programs.

Upon receipt of the application and medical questionnaire (**which is to completed by the applicant's physician**), the family should **call to schedule an interview** with me. The purpose of this visit is to further assess the ability of The Life Center to meet the needs of the applicant and their family and to acquaint the applicant with The Life Center.

The application must be completed in its entirety to be considered. It will be processed as quickly as possible; however, a ten-day working period should be allowed between the receipt of the application and medical form by The Life Center and the participant's first day of participation.

Please do not hesitate to call me at 249-2155 if you have any questions.

I look forward to meeting you and telling you more about our services.

Sincerely,

Robin Senter
Program Coordinator

October, 2005

Family information

- Who is responsible for the applicant (overseeing care, paying bills, etc.)?

Name: _____ Phone Number: (_____) _____ - _____

Mailing Address: _____

- Is this person a Power of Attorney for the applicant? _____

- If the applicant has children, please list their names, mailing addresses, and e-mail addresses

- If the applicant has grandchildren, please list their names.

About the applicant's doctors:

Name of Primary Care Physician _____ Phone Number (_____) _____ - _____

Mailing Address _____

- If you have more than one physician, please provide a list of all physicians.

Name of Dentist _____ Phone Number (_____) _____ - _____

Mailing Address _____

Emergency contact phone numbers-REQUIRED

There are times we might need to get in touch with a family member or friend. In the event of an emergency; To obtain necessary information: or if the participant is late, absent, or remains at The Life Center after closing. If a phone number changes, please provide new information.

Name _____ Relationship _____

Mailing Address _____

DAYtime Phone _____ Cellular Phone _____

Name _____ Relationship _____

Mailing Address _____

DAYtime Phone _____ Cellular Phone _____

About transportation

- Do you have transportation from your home to and from The Life Center? _____ Yes _____ No

If yes, who will provide transportation? _____

- Approximately what time will the applicant arrive? _____ am What time will they leave? _____ pm

If no, do you need for transportation to be arranged if available? _____ Yes _____ No

Additional information about the applicant

Please check below if any of the following apply. Please feel free to add additional comments when needed.

- The applicant is occasionally confused or disoriented (less than once a week).
- The applicant is frequently confused or disoriented (daily).
- The applicant has wandered away from home before. How many times? _____

- The applicant cannot feed him/herself.
- The applicant is on a special diet.
What type? No Added Salt ____, Low Salt ____, Diabetic ____, Ground Foods ____, Other _____
- The applicant has problems with choking. How frequently? _____

- The applicant has frequent loss of bowel or bladder control.
- The applicant wears a "Depends" type garment.
- The applicant needs assistance to go to the restroom.
- The applicant has had a mastectomy? When _____ L. side___ R. side___ Both___
- The applicant wears glasses.
- The applicant wears contact lenses.
- The applicant wears dentures.
- The applicant wears hearing aid (s).
- The applicant wears a pacemaker.
- The applicant has difficulty understanding normal conversations and following instructions.
- The applicant is unable to read or write.
- The applicant needs large print to read.

- The applicant has a history of seizures.
- The applicant has allergies. Please list.

- The applicant falls frequently. How frequently? _____
- The applicant uses a ___ walker, ___ cane, ___ wheelchair.
- The applicant needs assistance with ambulation.

- The applicant uses tobacco products. ___ Cigarettes ___ Chewing tobacco or snuff/dip
- The applicant has the following special care needs:

Is there any additional information which might help us to provide care to the applicant?

MEDICATIONS

Please list all of the applicant’s medications (prescription and over the counter) - **whether they will be taken at home or The Life Center.** Any changes should be reported in writing immediately as this information is provided to emergency personnel when needed. **This information is REQUIRED.**

Name of Medication	Dosage	When Taken	Why Prescribed

If additional medications are taken, please attach list.

- Which most accurately describes the applicant?
 Is able to take own medications without assistance.
 Needs reminding to take medications.
 Cannot take medications without assistance.
- Will the applicant be taking medications while at The Life Center? Yes No
- Does the applicant have any drug allergies? Yes No If yes, please explain.

NOTE: If the recipient and/or caregiver will pay for the cost of services, NO Financial Information is required.

The following information will be used by The Life Center to document the recipient’s eligibility for federal funding, and to allow The Life Center to apply for federal funding reimbursement. All information will remain confidential.

Please circle the total income of the applicant and their spouse if applicable. Income includes social security, pensions, dividends, retirement benefits, interest income from savings, bonds, and stocks, income from estates, trusts, royalties, and rental property, wages from employment, unemployment benefits, workers compensation, alimony, etc.

Monthly Income of:

Individual	Couple
\$903 - \$1,128	\$1,214 - \$1,518
\$1,129 - \$1,354	\$1,519 - \$1,821
\$1,355 - \$1,579	\$1,822 - \$2,125
\$1,580 - \$1,805	\$2,126 - \$2,428
\$1,806 - \$2,031	\$2,429 - \$2,732
\$2,032 - \$2,257	\$2,733 - \$3,035
\$2,258 - \$2,482	\$3,036 - \$3,339
\$2,483 - \$2,708	\$3,340 - \$3,642
\$2,709 - \$3,161	\$3,643 - \$4,249
\$3,162 - above	\$4,250 - above

- **How many days will applicant be attending each week? _____ Which days will s/he be attending?**
- **___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday** **Page 4**

• Expenses:

Please list monthly expenses incurred by the applicant:

Rent/Mortgage:	_____	Utilities	_____
Prescription Drug Costs:	_____	Home Modifications	_____
Special Needs Costs:	_____	Caregiving Costs	_____

• In the event of an emergency:

Please check if the applicant has any of the following documents:

_____ A Living Will
_____ Do Not Resuscitate Orders
_____ Advanced Directives
_____ Health Care Power of Attorney

Does the applicant have a hospital preference? If yes, please list the hospital.

Does the applicant have hospital insurance in addition to Medicare/Medicaid? ____ Yes ____ No
If yes, please list company and policy number(s):

• *The following are things we do in our day to day lives. Please check if the applicant is capable of accomplishing the following tasks.*

_____ *eat a meal without assistance*
_____ *dress without assistance*
_____ *take a bath without assistance*
_____ *go to the bathroom without assistance*
_____ *get up from a chair without assistance*
_____ *communicate wants/wishes/thoughts*
_____ *walk without staff assistance*
_____ *know when s/he have to go to the bathroom and is able to act on that urge*

_____ *prepare a meal without assistance*
_____ *take medication properly without assistance*
_____ *clean the house without assistance*
_____ *manage money properly without assistance*
_____ *make a phone call without assistance*
_____ *do laundry without assistance*
_____ *read a book*
_____ *go grocery shopping*

RELEASE OF INFORMATION

In the event of a medical emergency, I allow release of information necessary for The Life Center to determine the ability to meet the medical needs of the applicant.

I also allow release of information necessary for The Life Center to document my eligibility for federally funded programs.

I understand this information will not be used for any purpose other than to document my eligibility and feasibility to participate in the adult day program.

RELEASE FOR MEDICAL TREATMENT

- I AUTHORIZE THE STAFF OF The Life Center of Davidson County to assist the applicant’s taking of his/her medications as prescribed by his/her physician.
- I give my permission for emergency treatment as deemed necessary by The Life Center staff or emergency personnel.
- I give permission to be treated in the emergency room of the nearest hospital in the event of an emergency.
- I give permission for emergency treatment as deemed by a physician either in his/her office or emergency room.

CONSENT TO PHOTOGRAPH

I give permission to The Life Center of Davidson County for this named person _____ to be photographed for the purpose of promoting the services of The Life Center in newspaper articles, slide or video presentations, or television stories. I also allow The Life Center to retain film, negatives, or prints from such photographs.

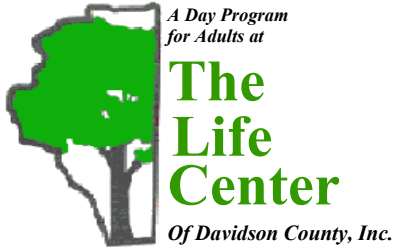
STATEMENT OF UNDERSTANDING

I have received a copy of the Family/Participant Handbook (Policies and Procedures of The Life Center) and understand the responsibilities of the family and The Life Center and agree to abide by them.

Applicant’s Signature _____ **Date** _____

Signature of Responsible Person _____ **Date** _____

Signature of Life Center Staff _____ **Date** _____



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TO THE MEDICAL CARE PROVIDER:

Attached you will find a two-page form which requests medical information about an individual who has expressed an interest in participating in our adult day health program. This form, along with your recommendations, will provide us with the information necessary to determine if The Life Center will be able to adequately meet the needs of the applicant and his/her family. **In the event of an emergency, the information you provide will also be given to emergency personnel.**

Your careful examination and written recommendations are most appreciated and helpful to our staff and our review committee. Any additional information you feel would be helpful to us would also be appreciated. If you do not find this an appropriate means of providing care for this participant, we would appreciate this input also.

A signed release to provide this information is attached for your records. The form may be returned directly to the family or to The Life Center. (Fax: 336-249-2374)

Should you have any questions about our services, please contact the Health Care Coordinator or me at 249-2155.

I am certain the family appreciates, as do we, your help and your timely completion of this form.

Sincerely,

Robin Senter
Program Coordinator



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TO THE APPLICANT AND FAMILY MEMBERS:

This form requests medical information from the physician of an applicant to The Life Center.

This form should be given to the applicant's physician for completion. The information provided to us on this form is **required** by State standards. The information also helps us to determine how we can best meet the medical needs of the applicant. The information is used solely by The Life Center of Davidson County to determine whether or not an adult day program is the appropriate health care option for the applicant.

The physician may return the form directly to you or send it to The Life Center.

Fax: 336-249-2374

The form must be completed in its entirety and received by The Life Center **before** the applicant's first day and will be due annually thereafter.

In order that the physician may release the information to The Life Center, please complete the portion below prior to giving this form to the physician.

I, _____, allow release of medical information
(Applicant or responsible Family Member)

about _____ to The Life Center of Davidson
(Applicant)

County for the purpose of determining the feasibility of the applicant's participation in an adult day program by his/her physician, Dr. _____.

October, 2005

MEDICAL INFORMATION FORM
THE LIFE CENTER OF DAVIDSON COUNTY

Name of Participant _____ Birth Date _____

Most Recent Date Seen by Physician: _____

MEDICAL DIAGNOSES: Please check: _____ COPD/Respiratory problems
____ Anemia ____ Anxiety Disorder ____ Arthritis
____ Asthma ____ BPH/PSA ____ CAD/Angina
____ CHF ____ Chronic Bronchitis ____ Cancer-Location: _____
____ Dementia ____ Alzheimer's ____ Chronic Renal Failure
____ Emphysema ____ Gastric Ulcers ____ Diabetes: Type I or Type II
____ GERD/Reflux ____ HTN ____ Epilepsy/Seizure Disorder
____ MI/Cardiac ____ Mentally Challenged ____ Parkinson's
____ Defib/Pacer ____ Depression ____ Cardiac Arrhythmias
____ Pneumonia ____ Atrial Fib. ____ Cardiomyopathy

Effects of Stroke: Specify: _____

Skin Disorder: Specify: _____

Psychiatric Issues-Specify: _____

Urinary Problems-Specify: _____

Visual Problems-Specify: _____

Hearing Problems-Specify: _____

ANY OTHER ILLNESSES NOT LISTED ABOVE:

____ YES ____ NO Does the participant have any **COMMUNICABLE** diseases?
If so, specify: _____

____ YES ____ NO Does the participant require constant supervision to make
sure he/she does **NOT** do harm to self, others or to property?

____ YES ____ NO Will this person wander off if not closely attended?

____ YES ____ NO Do you recommend any restrictions for medical reasons on
physical activities such as walking, exercise, etc?
If so, specify: _____

____ YES ____ NO Any **ALLERGIES** to medications, foods or Latex?
If so, specify reactions: _____

____ YES ____ NO Does the participant have difficulty understanding conversations
or communicating needs?

____ YES ____ NO Is the participant at a **HIGH RISK FOR FALLS**?

____ YES ____ NO Participant is at **HIGH RISK OF CHOKING**?

OVER PLEASE

