A Day Program for Adults at
The Life Center
of Davidson County, Inc.

To the Applicant, Family Member or Responsible Person:

Attached is an application for participation in the adult day care/adult day health program of The Life Center of Davidson County, Inc. 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 be completed by the applicant's physician), the family should call to schedule an interview with the Health Care Coordinator. 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.

Sincerely,

Elizabeth G. Rummage
Executive Director

Enclosures

601 West
Center Street
Lexington,
North Carolina
27292

Phone:
336-249-2155
FAX:
336-249-2374
email:
lifecenter@
lexcominc.net
www.
lifecenterdavidson.com

United Way
United Way of Davidson County
PARTNER AGENCY

A United Way of Davidson County Agency

PARTICIPANT AND FAMILY INFORMATION
The Life Center of Davidson County, Inc.

Applicant's Full Name: _____
First Middle Maiden Last

Applicant's Mailing Address: _____

City & Zip code: _____

Applicant's Home Phone: (_____) _____ - _____

Applicant's Social Security Number _____-_____-_____ **REQUIRED**

Applicant's Date of Birth _____/_____/_____ Email Address _____

Medicare Number _____ Medicaid Number _____

Does the recipient receive or has applied for Supplemental Security Income? (SSI) ____Y ____N

Is the participant receiving Adult Protective Services? ____Y ____N

Does the household receive Food Stamps? ____Y ____N

Name of person receiving Food Stamps: _____

To the family:

- What interested you in the services provided by The Life Center?
- How did you learn about The Life Center?
- Have you been involved with another adult day care/adult day health program?

About the Applicant: (This information helps us to get to know the applicant.)

- Is the applicant _____Single _____Married _____Divorced/Separated _____Widowed
- If they do not live alone, with whom do they live?
- Did the applicant work and if so where?
- Where did they attend school?
- What was the highest grade they completed?
- Are they a part of a faith based community?
- What hobbies does the applicant enjoy?
- What activities does the applicant participate in on a typical day?
- If currently receiving the services of a home health agency, which agency?
- Were they in the armed services? If so, when and in what branch did they serve?

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.

A bout 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: _____ Cell Phone: _____

Name: _____ Relationship: _____

Mailing Address:

_____

Daytime Phone: _____ Cell Phone: _____

About transportation

- Do you have transportation from your home to and from The Life Center? _____YES _____NO

If yes, who will provide the 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 _____ Left Side _____ Right Side _____Both _____
_____The applicant wears glasses.
_____The applicant wears contact lenses.
_____The applicant wears a pacemaker.
_____The applicant has difficulty understanding normal conversations and following instructions.
_____The applicant is unable to read and 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 taking them 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

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	$1,850-2,428
$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

- ***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
_____**D**o **N**ot **R**esuscitate 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

- **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 she/he has 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 t o 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** _____

A Day Program for Adults at
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TO THE APPLICANT AND FAMILY MEMBERS:

This form allows for the release of medical information from the physician of the applicant to The Life Center and should be given to the applicant's physician upon 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, Inc. 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 via fax. Our fax number is: 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 for the physician to release the information to The Life Center, please complete the following portion prior to giving this form to the physician.

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

about _____
(Applicant)

to The Life Center of Davidson County for the purpose of determining the feasibility of the applicant's participation in an adult day program by his/her physician,

Dr. _____.

Elizabeth G. Rummage
Executive Director

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Center Street
Lexington,
North Carolina
27292

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Medical Information Form
The Life Center of Davidson County

Name of Participant: _____

Birth Date: _____ Most Recent Date Seen By Physician: _____

Medical Diagnosis: Please Check:

_____ Anemia
_____ Asthma
_____ CHF
_____ Dementia
_____ Emphysema
_____ GERD/Reflux
_____ MI/Cardiac
_____ Defib/Pacer
_____ Pneumonia
_____ Anxiety Disorder
_____ BPH/PSA
_____ Chronic Bronchitis
_____ Alzheimer's
_____ Gastric Ulcers
_____ HTN
_____ Developmentally Disabled
_____ Depression
_____ Atrial Fib.
_____ COPD/Respiratory problems
_____ Arthritis
_____ CAD/Angina
_____ Cancer-Type: _____
_____ Chronic Renal Failure
_____ Diabetes: Type I or Type II
_____ Epilepsy/Seizure Disorder
_____ Parkinson's
_____ Cardiac Arrhythmias
_____ Cardiomyopathy
_____ Effects of Stroke - (Specify): _____
_____ Visual Problems - (Specify): _____
_____ Hearing Problems - (Specify): _____
_____ Urinary Problems: - (Specify): _____
_____ Skin Disorder - (Specify): _____
_____ Psychiatric Issues - (Specify): _____

ANY OTHER ILLNESSES NOT LISTED ABOVE: _____

_____ YES _____ NO Does the participant have any COMMUNICABLE disease?
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 if not closely attended to?

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

_____ YES _____ NO Does the participant have 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 a HIGH RISK FOR FALLS?

_____ YES _____ NO Is the participant at HIGH RISK OF CHOKING?

_____ YES _____ NO Does the participant have any special dietary needs?
If so, specify: _____

Consistency: Reg. _____ Cut up _____ Chopped _____ Ground _____ Thicket _____

The Life Center Provides an 1800 calorie ADA diet.

Medications	Strength	Time Given	Purpose

PRN STANDING ORDERS FOR MEDICATION:

Please Check if the following may be given at The Life Center:

_____ YES _____ NO Tylenol (Acetaminophen) 500 mg-2 tabs/caplets PO or elixir q 6 hrs PRN for mild pain or temperature greater than 100 degrees.

_____ YES _____ NO Robitussin 15cc PO q 4 hrs PRN for simple cough-Not to exceed 4 does in 24 hours.

_____ YES _____ NO Mylanta/Maalox 30cc PO q 4 hrs PRN for indigestion-Not to exceed 4 does in 24 hours.

_____ YES _____ NO Triple Antibiotic Ointment to minor abrasions and wounds PRN. May use Steri-Strips if needed.

_____ YES _____ NO Cold Compresses for simple trauma & Warm Compresses for pain or inflammation.

_____ YES _____ NO Menthol Cough Drops q 2 hrs PRN for cough or sore throat.

_____ YES _____ NO Milk of Magnesium 30cc q day PRN for constipation.

LIST ANY OTHER OTC MEDICATIONS THAT ARE TO BE GIVEN:

The Life Center requires a TB test be current **within 3 months of Enrollment only**. If you are reauthorizing this form, a TB test is Not required.

Date of TB Test: _____ Results: _____

Participants typical Blood Pressure: _____ Blood Sugar: _____

Height: _____ Weight: _____

The Life Center monitors the participants' Blood Pressure and Weight Monthly.

Printed Name of PCP/PA/NP: _____ Date: _____

Signature of PCP/PA/NP: _____ Date: _____

Name of Practice: _____

Address: _____

Phone: _____ Fax: _____