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Iredell Adult Day Services
FKA ElderCenter, Inc. Adult Day Care

For office use only
❑DSS ❑COA ❑PACE

CLIENT APPLICATION

Name First: **MI:** **Last:**

Address:

Phone: **Cell:**

DOB: ❑ **Male** ❑ **Female** **SSN:**

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Present living arrangements are with:
❑ Spouse ❑ Relative(s) ❑ Non-relative ❑ Alone in House /Apt ❑ Alone in a single room

Living with whom (if not alone): **Relationship**:

If living with someone, is the person staying with you: **Employed** ❑Yes ❑No

Name of Employer: **Employer Phone:**

Why are you interested in this program?
❑ Cannot stay home alone ❑ Companionship ❑ Activities ❑ Other:_____

Have you attended a Day Program before? ❑ Yes ❑ No
If yes, where and when:

Main Caregiver Contact: **Relationship:**

Name First: **Last:**

Address (check ❑ if same as above)

Phone: **Cell:** **Work:**

Nearest Responsible Relative/POA Guardian:

Phone: **Relationship:**

Address (if not living with applicant)

EMERGENCY CONTACT INFORMATION

Please list 2 people who may be contacted in case of emergency

1. Contact Name: **Relationship:**

Address (if different than above)**:**

Phone: **Cell:** **Work:**

2. Contact Name: **Relationship:**

Address (if different than above)**:**

Phone: **Cell:** **Work:**

Primary Physician: **Phone:**

Dentist: **Phone:**

How did you hear about us? ❑Friend ❑Referral from ❑Ad ❑Event

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Applicant/Client Name:

SERVICES

Transportation provided by: ❑ Relative or Friend ❑ Public Transportation ICATS ❑ Other:_____

Check if coming: ❑ Everyday **Same Time**: Drop off: _____ Pick Up:_____

If times and days vary please complete below:

Week 1	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival time					
Departure					
Week2	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival time					
Departure					
Week 3	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival time					
Departure					
Week 4	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival time					
Departure					
Week 5	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Arrival time					
Departure					

Special Dietary Needs, if any:

Please attach a copy of the doctor's orders if on a therapeutic diet.

Supportive devices: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Hearing Aid ❑ Dentures ❑ Eyeglasses (contacts)

Other:_____

Advance Directive Notification

❑ Applicant does not require a POA, may make his/her own medical or other decisions and may sign for himself/herself legally.

❑ My family member has a Power of Attorney or legal guardian

Name of POA/Guardian: Phone:

❑ My family does not have an advance directive:

- ❑ I would like information on how to obtain an advance directive
- ❑ My family member does not want an advance directive

❑ My family member/applicant has a DNR order (please provide a copy of DNR on yellow paper)

The day care (Iredell Adult Day Services/ElderCenter, Inc.) program's policies have been explained to me and/or my POA/guardian and I have been given a copy of them and agree to abide by them. If emergency medical care becomes necessary, I give permission for any treatment the physician deems necessary.

Applicant's signature: **Date:**

Responsible party's signature: **Date:**

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Applicant/Client Name:

MEDICAL INFORMATION/HISTORY

The individual listed below desires or has enrolled in a Day Program for Adults. Supervision is provided during the day for elderly, disabled or memory impaired adults in a protective setting approved by the NC State Department of Health and Human Services/Resources, Division of Aging and Adult Services to provide for personal care to promote social, physical and emotional well-being and to offer opportunities for companionship, self-education and leisure time activities.

In order to protect both the applicant and other participants, it is necessary that we have medical information on each person. This information will also assist the Day Activity Personnel in working with this person.

Applicant/Client Name: **DOB:**

Most recent doctor's visit date: **TB test** *(optional)* **Date:** ❑ **Positive** ❑ **Negative**

Blood pressure: **Pulse/Respiration: /** **Weight:**

PHYSICAL HEALTH HISTORY - Please check all that apply:

☑	Issue	Comment	☑	Issue	Comment
❑	Arthritis Rheumatism		❑	Gastro-intestinal problems	
❑	Asthma		❑	Urinary Tract/Incontinence	
❑	Emphysema Chronic Bronchitis		❑	Anemia	
❑	Tuberculosis		❑	Stroke - issues	
❑	High Blood Pressure		❑	Epilepsy	
❑	Heart condition		❑	Glandular Issues	
❑	HIV		❑	Allergies – note which	
❑	Circulation problems		❑	Skin disorders	
❑	Stomach ulcers		❑	Cancer	
❑	Diabetes		❑	Other	

Please use the back of this page for other comments regarding health issues.

Primary diagnosis: **Secondary diagnosis:**

Other health symptoms – please check all that apply:

☑	Issue	☑	Issue	☑	Issue
❑	Malnourishment	❑	Change in bowel habit	❑	Shortness of breath
❑	Lumps	❑	Blood in Urine	❑	Dizziness
❑	Persistent cough	❑	Hearing issues	❑	Vision
❑	Severe headache	❑	Sudden weight loss	❑	Other
❑	Vomiting	❑	Severe chest pains	❑	

Medication applicant/client is taking for physical health issues:

Medication	Dosage	Frequency

COVID Vaccination ❑ Y ❑ N | ❑ Moderna ❑Pfizer ❑Johnson & Johnson **Date 1st** **Date 2nd**

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Client/Applicant Name:

MENTAL HEALTH STATUS

Please check all that apply:

❑ Organic Brain Damage ❑ Brain Disease ❑ Traumatic Brain Injury
❑ Personality Disorder: _____
Diagnosed with: ❑ Dementia ❑ Alzheimer's ❑ Lewy /Body
❑Other:_____

Please check all that apply:

☑	Issue		Issue		Issue
❑	Loss of Appetite	❑	Hallucinations	❑	Orientation problem
❑	Insomnia	❑	Delusions	❑	Hazardous behavior
❑	Feeling worthless	❑	Distortions in thinking	❑	Alcohol Abuse
❑	Lose Interest	❑	Confusion	❑	Drug abuse
❑	Hypochondria	❑	Impaired judgement	❑	Other:
❑	Suspiciousness		Memory loss		

Medication applicant/client is taking for mental health issues:

Medication	Dosage	Frequency

General information – please check all that apply:

❑ The client/applicant requires constant supervision to make sure harm is not done to self, others or property.
❑ This person wanders off if not closely attended.
❑ This client/applicant can do light exercises from a sitting position, such as leg lifts, arm lifts, etc.
Recommend special types of activities such as: ❑ Group activities ❑ Arts & crafts ❑ Physical exercise,
❑ Training for self-care ❑ Reading ❑ Puzzles Other_____
❑ Requires a special diet – please describe below or attach doctors therapeutic diet requirement. **See pg 5.**

Please comment on any physical, mental, or emotional condition apparent from your knowledge of the above-named person that might need further explanation or might affect other participants.

I certify that I have today reviewed the health history and examined this person and find him/her physically able to participate in an adult day care activity program:

Please sign by a M.D., P.A., or Nurse Practitioner:

Signed by Date:

Print name:

Address

City/State/Zip: Phone

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Client/Applicant Name:

FOR PHYSICIAN : INFORMATION ABOUT OUR DIETARY SPECIFICATIONS

Applicant Physician: Please read our regulations about our diet and nutrition. A "special diet" may not be required. Our Registered Dietician qualifies our menus as low sugar/sodium and heart healthy. If satisfied with this, then the question about special diet should be answered "No."

Iredell Adult Day Services/ElderCenter is very concerned about our participants' diet and nutrition. We have a registered dietician who evaluates our menus and certifies that each participant is being offered healthy meals and snacks. The lunch meal meets or exceeds 1/3 of the adult's daily nutritional requirement as specified by the Dietary Guidelines for Americans. Snacks and meals offer good nutritional value while keeping fat and cholesterol to a minimum. Low fat options are purchased as available. Fruit is purchased in its own juice and is not to exceed 15 grams of carbohydrates per ½ cup serving. Saltshakers have been removed from the eating areas and Mrs. Dash is used for seasoning during cooking. Our menus reflect a "no concentrated sweets" and "no added salt restriction" to meet the needs of all program participants. Please indicate below any food allergies or food restrictions your patient may have.

❑ **Yes**, the above stated dietary plan is satisfactory for my patient as ordered by me while attending the Day Program.

❑ **No**, please adhere to the attached special diet I prescribed for this patient.

Food restrictions: _____

_____

Food allergies: _____

Please sign and date this form to be returned to Iredell Adult Day Services/ElderCenter.

Physician signature: _____ **Date:** _____

Comments: _____

_____

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Client/Applicant:

LIST OF ALL MEDICINES & WAIVER

To be prepared for the emergencies that can and do happen, please list below all medications being taken either at the Center or at home by the participant. This will provide the rescue squad and first responders with the vital medical information that is necessary to administer proper treatment. It is important that the staff at the Center be given in writing any changes in medication to keep our records current.

I hereby authorize the personnel of Iredell Adult Day Services to administer the medicine(s) listed below. In doing so, I hereby release said program, its officers, staff and personnel, from any and all iability that might arise as a result of the medication being administered and hereby waive any action which I may have as a result of the medication being administered. I will be notified when the medicine supply is low. Furthermore, I release the fore said from any and all liability that might arise as a result of said medication not being administered because the supply was not replenished.

Signature of Applicant or Guardian: **Date:**

PARTICIPANT'S COMPLETE MEDICATION LIST

Please ☑ check all that are to be given while at the Day Program Facility:

☑	Time	Medication	Dosage	Frequency	Notes
❑					
❑					
❑					
❑					
❑					
❑					
❑					
❑					
❑					
❑					

I also give permission for participant to take the following over-the-counter medication if requested:
❑ Tylenol ❑ Pepto Bismol ❑Other:_____
Allergies:

Medication Policy:
State regulations prohibit administering any medication not in the original container from the doctor or pharmacy. North Carolina Adult Day Care Standards for Certification state that medications kept by the program shall be in containers in which they were dispensed from the pharmacy. The containers shall be clearly labeled with the participant's full name, the name and strength of the medicine, dosage, and instructions for administration. Only medication that meet this stated criterion will be given. Most pharmacies will give two containers if asked. Pills brought to the center in envelopes, pill boxes or other containers not meeting the above description cannot be given.

With everyone's safety in mind, it is necessary to strictly comply with this policy. It is not intended to be a hardship on anyone, safety first. Thank you for your cooperation.

❑ I have read the above policy and agree to adhere to it.

Signature: **Date:**

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Client/Applicant:

WAIVER – AUTHORIZATION TO RELEASE INFORMATION

I, (participant name) _____, agree for Iredell Adult Day Services/ElderCenter, Inc. to release information about myself to first responders, EMS, COA (Council on Aging), DSS (Department of Social Services), CACFP (Child and Adult Care Food Program) and/or United Way. I understand that Iredell Adult Day Services/ElderCenter, Inc. is requesting this information in order to assist me and that the information obtained will be kept confidential and shared with no other agency or organization without my written consent.

Signature Participant or Guardian/POA: **Date:**

PHOTOGRAPHIC RELEASE

I, _____ as a participant of Iredell Adult Day Services/ElderCenter, Inc. agree to photographs, digital media or videos being taken of me as an individual or in a group as part of this program's community. I have been informed that these images as stated above may be used in publicity and community outreach efforts to promote the mission of Iredell Adult Day Services/ElderCenter, Inc to the general public. These images may be used in a slide presentation, on our website, in local news media, brochures, ads, or other media and publications.

Signature Participant or Guardian/POA: **Date:**

IADS/ElderCenter, Inc. Representative: **Date:**

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INITIAL ASSESSMENT GUIDELINES

During the initial personal interview with the applicant prior to start date, identify the following:

Social Needs:

Medical Care Needs:

Spiritual, Religious or Cultural Needs:

Strengths:

Abilities:

Can this program meet the individuals needs? ❑ Yes ❑ No

Interview conducted by (IADS staff): **Date:**

Please sign

Please check off completed documentation:

- ❑ Completed application
- ❑ Advanced Directive
- ❑ Medical & Mental Health history and Physicians signature
- ❑ Dietary Policy Signed
- ❑ List of Medications & Waiver to administer
- ❑ Information release & Photograph Waivers signed
- ❑ Discussed program policies and provided a copy

Notes page: