Please print out, complete, and return to us.

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), and/or CACFP (Child and Adult Care Food Program). 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 in perpetuity. 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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Client/Applicant:

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

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

Adult Enrollment Form

INSTITUTION NAME:_____ FACILITY NAME:_____ AGREEMENT#: _____

This facility is involved in the U.S. Department of Agriculture (USDA) Child and Adult Care FoodProgram (CACFP). CACFP needs proof of enrollment for all participants. Please complete the following information. Be sure to sign and date in the space provided. Thank you.

This information can be provided by the participant or an adult household member.

Participant's Name:	**Participant's Age:**	
Is the adult participant 60 years of age or older?	☐ Yes	☐ No
Is the adult participant a "*functionally impaired adult*"?	☐ Yes	☐ No
7 CFR §226.2 defines "functionally impaired adult" as "chronically impaired disable persons 18 years of age or older, including victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction, who are physically or mentally impaired to the extent that their capacity for independence and their ability to carry out activities of daily living is markedly limited. Activities of daily living include, but are not limited to, adaptive activities such as cleaning, shopping, cooking, taking public transportation, maintaining a residence, caring appropriately for one's grooming or hygiene, using telephones and directories, or using a post office. Marked limitations refer to the severity of impairment, and not the number of limited activities and occur when the degree of limitations is such as to seriously interfere with the ability to function independently."		
Does the adult participant reside in his/her own home?	Resides in own home: ☐ Yes	☐ No
If the adult participant does not reside in his/her own home, does the adult participant reside in a *"group living arrangement"*?	Group living arrangement: ☐ Yes	☐ No
7 CFR §226.2 defines "group living arrangement" as "residential communities which may or may not be subsidized by federal, State or local funds but which are private residences housing an individual or a group of individuals who are primarily responsible for their own care and who maintain a presence in the community but who may receive on-site monitoring."		
If the adult participant does not reside in his/her own home or in a *"group living arrangement"* please describe the type of residence: _____		

Participant/Adult Household Member Signature:_____ **Date**: _____

Printed Name of Person Signing Above: _____

Address: _____ City:_____ State: _____ Zip Code: _____

Home Telephone Number: ( )_____ Work Telephone Number: ( ) _____

For Institution Use Only:

Signature of Institution's Representative:_____ Date: _____

Date the participant enrolled:_____ Date the participant withdrew: _____

This institution is an equal opportunity provider.

North Carolina Department of Health and Human Services
Division of Child and Family Well-Being, Community Nutrition Services Section
Child and Adult Care Food Program

ADULT INCOME ELIGIBILITY APPLICATION

INSTITUTION NAME: _____ FACILITY NAME: _____ AGREEMENT#: _____

1. Participant Name: _____
   First Last

2. MEDICAID, SNAP, Supplemental Security Income (SSI), or FDPIR: Provide the participant's case or program number if applicable.

   Medicaid # _____ **SNAP #** _____

   SSI # _____(Last 4 digits only) **FDPIR #**_____

   If you have provided a Medicaid, SNAP, SSI, or FDPIR number, **do not complete #3. Complete #4 (voluntary) and #5**.

3. HOUSEHOLD INCOME: List the income of the participant, and if residing with the participant, their spouse, and any *dependents of the adult participant who reside with them*. List all gross income **(before deductions)** received last month.
   If you did not give a Medicaid, SSI, FDPIR and/or SNAP case number, you must complete the income information.

Names of Household Members	Monthly Wages/Salaries	Monthly Social Security	Monthly Retirement Pensions Earnings	Other Monthly Earnings
	$	$	$	$
	$	$	$	$
	$	$	$	$

4. ETHNIC IDENTITY: (Check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

   RACE: (Check one or more) ☐ White ☐ Black or African American ☐ Asian
   ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander

5. SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER: I certify that all the above information is true and correct, and that all income is reported. I understand that this information is being given for the receipt of federal funds; that Program officials may verify the information on the application and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

_____ _____ Check if no SSN ☐
Signature of Participant or Adult Household Member - Required Date Last four digits of the Social Security number (Required for households qualifying by income)

_____ _____
Printed Name Telephone #

_____
Address

For Institution Use Only

TOTAL HOUSEHOLD SIZE: _____ TOTAL HOUSEHOLD MONTHLY INCOME: $_____

Approved: ☐ Free ☐ Reduced-Price ☐ Denied

Reason for denial: ☐ Income too high ☐ Incomplete application ☐ Other_____

Withdrew on (Date) _____

For state use only:
Verified by: _____ Date: _____
Verified classification:
☐ Free ☐ Reduced-Price ☐ Denied
Reason for change in classification: _____

_____ _____
Signature of Eligibility Official (Individual at the Institution level) - Required Date – Required

NC CACFP ADULT INCOME ELIGIBILITY APPLICATION INSTRUCTIONS

Please complete the Child and Adult Care Food Program Adult Income Eligibility Application using the instructions below. Sign the statement and return it to the adult day care center.

1 - PARTICIPANT'S INFORMATION: Complete this part.

Print the name of the adult participant enrolled in the center.

2 - HOUSEHOLDS RECEIVING MEDICAID, SNAP, SSI, OR FDPIR BENEFITS:
Complete part 2 and part 5.

1. List the current SNAP, Medicaid, SSI, or FDPIR case or program number.
2. An adult household member must sign the statement in part 5.

3 - HOUSEHOLD INCOME:

1. List the income of the participant, and if residing with the participant, their spouse, and any *dependents of the adult participant who reside with them*.
2. Write the amount of income (the amount before taxes or anything else is taken out), the frequency of income (i.e. weekly, every two weeks, twice a month, or monthly) received last month for each person listed and where it came from, such as earnings, welfare, pensions and other income (refer to examples below for types of income to report). If any amount last month was less than usual, write the person's usual income.
3. An adult household member must sign this income eligibility statement and give the last four digits of his/her security number in PART 5.

Monthly Income Conversion: Weekly X 4.33 Every 2 Weeks X 2.15 Twice a Month X 2

INCOME TO REPORT

<table>
<tr><th>Earnings from Employment</th><th>Pensions/Retirement/Social Security</th><th rowspan="3">Other Income</th></tr>
<tr><td>Wage/Salaries/Tips
Strike Benefits
Unemployment Compensation
Worker's Compensation
Net Income from Self-Owned Business or Farm</td><td>Pensions
Supplemental Security Income
Retirement Income
Veteran's Payments
Social Security</td></tr>
<tr><td>Welfare/Child Support/Alimony</td><td>Military Households</td></tr>
<tr><td>Public Assistance payments
Welfare payments
Alimony/Child support payments</td><td>All cash income including military housing/uniform allowances. Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food medical care, etc.)</td><td>Disability Benefits
Cash withdrawn from savings
Interest/Dividends
Income from Estates/Trusts/Investments
Regular contributions from persons not living in the household
Net Royalties/Annuities
Net Rental Income
Any Other Income</td></tr>
</table>

4-ETHNIC/RACIAL IDENTITY: Complete the Ethnic/Racial identity question.

Select the Ethnic Identity and Race of the Participant.

5-SIGNATURE AND LAST FOUR DIGITS OF THE SOCIAL SECURITY NUMBER:

All households complete this part.

1. All eligibility statements must have the signature of an adult household member.
2. If the participant is qualifying by income, the adult household member who signs the statement must include **the last four digits** of his/her social security number. If he/she does not have a social security number, write "none". If you listed a SNAP, Medicaid, SSI, or FDPIR number, the last four digits of a social security number is not needed.

ADULT PARTICIPANT HOUSEHOLD LETTER FOR NON-PRICING INSTITUTIONS
CHILD AND ADULT CARE FOOD PROGRAM

Dear Participant or Adult Household Member,

Please help us comply with the federal requirement mandating the annual submission of Program Eligibility Application. This application will be used only for eligibility determination, placed in our files, and treated as confidential information. For participants and the day care center to be considered eligible for program benefits, the adult participant or an adult household member must complete the Program Eligibility Application for each participant enrolled in the center as soon as possible, sign, date and return it to the day care center. Completion of the application is not mandatory for participants unless you which to be considered for eligibility as a free or reduced priced participant.

Medicaid, SNAP, Supplemental Security Income (SSI), or Food Distribution Program on Indian Reservations (FDPIR) participants: If the participant currently receives SNAP, SSI, Medicaid or FDPIR the participant is automatically eligible for free meals. You only have to list the SNAP case number, SSI, Medicaid or FDPIR identification number, sign, date and return the application.

Household Income: If the participant does not participate in any of the programs mentioned above but the participant's household income is at or below the level shown on the scale below, the participant is eligible for either free or reduced-price meals. To apply for meal benefits, the following information must be provided, or the application cannot be approved.

***Household Members**: List the income of the participant, and, if residing with the participant, their spouse, and any *dependents of the adult participant who reside with them*.
***Current Income**: List the amount of income each person (participant, spouse, and dependent children) received last month (BEFORE deductions for taxes, social security, etc.), frequency of income and where it is from, such as wages, retirement, or public assistance. If any household member's income last month was higher or lower than usual, list that person's expected average monthly income.
***Signature**: an adult household member must sign the application.
***Social Security Number**: If the participant is qualifying by income, list the last four digits of the social security number of the adult who signs the application. If that adult does not have a social security number, print "None".

If you have a household member whose last month's income was higher or lower than usual, list that person's expected average monthly income.

REDUCED GUIDELINES EFFECTIVE JULY 1, 2023 - JUNE 30, 2024*

HOUSEHOLD SIZE	YEARLY	MONTHLY	TWICE PER MONTH	EVERY TWO WEEKS	WEEKLY
1	$26,973	$2,248	$1,124	$1,038	$519
2	$36,482	$3,041	$1,521	$1,404	$702
3	$45,991	$3,833	$1,917	$1,769	$885
4	$55,500	$4,625	$2,313	$2,135	$1,068
5	$65,009	$5,418	$2,709	$2,501	$1,251
6	$74,518	$6,210	$3,105	$2,867	$1,434
7	$84,027	$7,003	$3,502	$3,232	$1,616
8	$93,536	$7,795	$3,898	$3,598	$1,799
For each additional family member add:	$9,509	$793	$397	$366	$183

*Households with income less than or equal to these levels are eligible for free or reduced-price meals.

You may submit a program eligibility application any time during the fiscal year. Participants having family members who become unemployed are eligible for free or reduced-price meals during the period of unemployment, provided that the loss of income causes the family's income during the period of unemployment to be within the eligibility standards for those meals.

COMPREHENSIVE ASSESSMENT AND SERVICE PLAN COMPONENTS

- Include input from the participant, family members or other caregiver, and other agency professionals with knowledge of the individual's needs.
- Base the service plan on strengths, needs, and abilities identified in the initial assessment.
- Review at a minimum of every six months.

☐ Number of IADL (Instrumental Activities of Daily Living)

Client (care recipient) can carry out the following tasks without help:

a. Prepare meals	☐ YES	☐ NO
b. Shop for personal items	☐ YES	☐ NO
c. Manage own medications	☐ YES	☐ NO
d. Manage own money (pay bills)	☐ YES	☐ NO
e. Use telephone	☐ YES	☐ NO
f. Do heavy housework	☐ YES	☐ NO
g. Do light cleaning	☐ YES	☐ NO
h. Transportation ability	☐ YES	☐ NO

TOTAL IADLs [add # of *No's*] _____

☐ Number of ADL (Activities of Daily Living)

a. Eat	☐ YES	☐ NO
b. Get dressed	☐ YES	☐ NO
c. Bathe self	☐ YES	☐ NO
d. Use the toilet	☐ YES	☐ NO
e. Transfer into/out of bed/chair	☐ YES	☐ NO
f. Ambulate (walk or move about the house without anyone's help)	☐ YES	☐ NO

TOTAL ADLs [add # of *No's*] _____

☐ Mental Environment
☐ Social Environment
☐ Living Environment
☐ Physical Health Status
☐ Needs and Strengths
☐ Interests
☐ Economic Status

Include:

☐ Measurable service goals and objectives of care for the participant
☐ Services to be provided by the program in order to reach the desired outcomes
☐ The roles of participant, family, caregiver, volunteers, and program staff
☐ The time limit for the plan, with provision for review and renewal

Service Plan signed and dated by the program director or director's designee.
Health component of the plan written and signed by a Registered Nurse.