Wilder Adult Day Services

Intake Screening/Application

Date _____

For Program Use Only

Visit Date _____

Start Date _____

Days Attending: M T W TH F

Transportation _____

Funding Type_____

Amount _____

Name (Mr. Mrs. Ms.) First_____ **Middle**_____ **Last** _____

Address _____Apt #_____ City _____

State_____ Zip _____Phone #_____

County _____ Annual Income _____

Date of Birth_____ Age _____Place of Birth _____

Marital Status_____# of Dependents _____ How do you identify yourself? Male___ Female___ Other_____

Medicare # _____ Medicaid/PMI # _____

Funding source _____ Insured's Name _____

Policy # _____ Group # _____

Primary Physician _____ **Specialty Physician** _____

Clinic _____ Clinic _____

Address _____ Address _____

City _____ City _____

State _____ Zip _____ State _____ Zip _____

Phone # _____ Phone # _____

Date of most recent PCP visit: _____Preferred Hospital _____

First Emergency Contact

Name _____

Relationship _____

Address _____

_____City_____

State _____ Zip _____

Phone (H) _____ (W) _____

Cell _____

Email _____

Second Emergency Contact

Name _____

Relationship _____

Address _____

_____City_____

State _____ Zip _____

Phone (H) _____ (W) _____

Cell _____

Email _____

Applicant Name _____

Where did you learn about Wilder Adult Day Health?

[ ] Print Materials
[ ] Doctor
[ ] Website
[ ] Case Manager
[ ] Home Health Agency
[ ] Phone Book
[ ] Workplace
[ ] Support Group
[ ] TCU
[ ] Hospital
[ ] Alzheimer's Association
[ ] Friend/Acquaintance
[ ] Nursing Home
[ ] Other (specify) _____

Primary Care Partners:

[ ] None/Self
[ ] Child
[ ] Friend
[ ] Spouse
[ ] Other Relative
[ ] Other (specify) _____
[ ] Guardian
[ ] Parent

Name of partner(s):_____

Name of person(s) with authority to sign for services/consent:_____

Source of authority (i.e. POA/ health directive etc):_____

Please check if client has any of the following: Bring copies on Admission for file

[ ] Power of Attorney
[ ] Health Care POA
[ ] Conservator
[ ] Alzheimer's Safe Return/Medic Alert
[ ] Guardian
[ ] Advance Directive
[ ] Durable Power of Attorney

Code Status- [ ] Full [ ] DNR/DNI

Living Arrangements:

[ ] Alone
[ ] Adult child
[ ] Friend
[ ] Spouse
[ ] Relative
[ ] Other _____
[ ] Parent
[ ] Paid caregiver

Housing Type: [ ]House [ ] Apartment [ ] Assisted Living Facility [ ] Townhome/Condo [ ] Other_____

How do you gain access to your home? (i.e., key) _____

Race: Select all that apply

[ ] Asian
[ ] Hispanic
[ ] Unknown
[ ] Black or African American
[ ] Native Hawaiian or other Pacific Island
[ ] Other_____
[ ] White or Caucasian
[ ] American Indian or Alaska Native
[ ] Declined information

Ethnicity: [ ] Not Hispanic [ ]Hispanic/Latino [ ]Decline [ ]Unknown

Religious Preference: _____ **Primary Language:** _____

Education:

[ ] Grade level under 8th grade List grade____ [ ] High school diploma/GED [ ] Four year college degree
[ ] Vocational/Technical School [ ] Some college level (freshman, soph etc.)_____
[ ] Graduate/Professional School [ ] Unknown

Occupation: _____ **Job Title:** _____

Transportation:

Who will provide transportation to ADH?

_____

Phone # _____

Who will provide transportation home?

_____

Phone # _____

Applicant Name _____

Metro Mobility # _____ or, Date Applied for _____

Billing:

Who should we send the bill to?

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Email _____

Case Manager

Name _____

Agency _____

Address _____

City _____ State _____ Zip _____

Phone _____

Email _____

To help us explore various funding options check those that apply:

[ ] Are you a veteran? What Branch? _____

[ ] Have you had a mental health diagnosis?

[ ] Do you have Medicaid?

[ ] Are you the spouse of a veteran?

[ ] Do you have a Long Term Care insurance policy?

Insurance Company _____

Policy Numbers _____

Medical/Medications

Please print the names of prescriptions and over the counter medications (including vitamins and herbals) in the spaces below (refer to labels on prescription bottles). Or attach medication list.

Name of Medication	Dosage	Time medicine is taken	Prescribing Doctor

Allergies – Food or Medication	Type of Reaction

Diagnosis:(please check those that apply) and **date of diagnosis**

[ ] Alzheimer's Disease Date_____

[ ] Other dementia Date_____

[ ] Stroke Date_____

[ ] Heart disease/Hypertension Date_____

[ ] Mental Health disorders Date____

[ ] Diabetes Date_____

[ ] Gastrointestinal Disorders Date_____

[ ] Glaucoma/Macular Degeneration

[ ] Parkinson's disease Date_____

[ ] Other neurological disorder Date_____

[ ] COPD/Emphysema Date_____

[ ] Arthritis Date_____

[ ] Cancer Date_____

[ ] Other (please specify) Date____ _____

WE CAN PROVIDE OR COORDINATE THE FOLLOWING SERVICES. For some, there may be an additional charge. Please check any that you are interested in discussing with us.

[ ] Hair Salon

[ ] Caregiver Support Groups

[ ] Bathing

[ ] Caregiver Services

[ ] Primary Care

[ ] Meals On wheels

IN-HOME SERVICES. Please check those that the applicant is currently using.

[ ] No In-Home Services

[ ] Meals on Wheels

[ ] Homemaker/Chore Services

Applicant Name _____

[ ] Visiting Nurse	[ ] Companion	[ ] Home Health Aide
[ ] Physical Therapy	[ ] Speech Therapy	[ ] Occupational Therapy
[ ] Lab/Blood Work	[ ] ILS Worker	[ ] Other, please specify _____

[LEFT BLANK INTENTIONALLY]

Applicant Name _____

NEEDS ASSESSMENT

Please complete to the best of your knowledge by checking all that apply to assist us in caring for the applicant. your

DAILY ACTIVITIES/FUNCTIONAL STATUS Add any comments that apply after categories identified.	Check	Program Assessment Program use only	Goal Area
DIET/NUTRITION			
Requires special diet			
Needs assistance at mealtimes			
Any trouble swallowing			
Any trouble chewing			
Good appetite			
Preferred beverage			
Problem foods or beverage			
COMMUNICATION			
Inability to speak clearly			
Unable to communicate basic needs			
AMBULATION			
Difficulty walking			
Any falls in last 6 months How many			
Use of wheelchair, cane, walker, other Identify:			
Needs assistance with walking and or transferring __one person __ two person			
SELF CARE			
Neglecting self-care			
Requires assistance in ___ dressing ___bathing			

Applicant Name _____

MEMORY Check any that apply		Program Assessment	Goal Area
__Unable to recognize people or thing __Problems with wandering __Worries about memory loss __Loses or hides things __Short attention span __Poor Judgment	__Repeats self __Lack of interest __Has crying spells __Forgets where he/she is __Difficulty with numbers __Uncomfortable in group settings		
Comments on Memory concerns:			

NEURO-MUSCULAR	Check	Program Assessment	Goal Area
Seizures			
Pain			
Paralysis Right__ Left__ Complete__ Upper__ Lower__			

GASTRO-INTESTINAL			
Problems with constipation			
___Diarrhea ___Heartburn ___Other			

TOILETING			
Independent with toileting			
Needs assistance toileting			
Loses control of ___ Bladder ___ Bowel			
Use of incontinence garments			
Manages with bathroom schedule to prevent incontinence			

EARS, EYES, NOSE, THROAT			
Trouble with vision/wears glasses			
Difficulty hearing/uses hearing aids			

Applicant Name _____

RESPIRATORY	Check	Program Assessment	Goal Area
Use of oxygen			
__Wheezing ___ Nebulizer __Inhalers			
History of Pneumonia			
History of Tuberculosis			
Has sleep apneas Uses a C-pap machine			

CARDIOVASCULAR			
Swelling or edema in any areas of body			
Implanted pacemaker or defibrillator			

SKIN			
Any skin rashes, itches or change in pigmentation			

PSYCHO-SOCIAL			
Awareness Level: Alert Confusion Anxious Depressed Other			
Angry or agitated			
Hallucinations/Delusions			
Previous psychiatric care			
Use of alcohol, tobacco, drugs			
Any changes in living situation			
Hobbies, interest areas		Groups activities identified by Program for participation:	

Applicant Name _____

Caregiver Information **Name:**	How long have you been primary caregiver?

Caregiver Employment Status: Full time ____ Part time _____ Doesn't work ____ Will work _____
Comments:

Who do you count on for support?

Do you feel appreciated by care receiver? Yes ___ No ____ Sometimes ___

Do you attend a caregiver support group or dementia trainings?
Yes ____ No _____ Planning to _____

Would you like information on groups?
Yes ____ No _____ In the future _____

Have you attended any caregiver trainings or dementia presentations? Yes _____ No _____
If Yes, please list:

Will it be ok if Wilder Caregiver Services contacts you? Yes____ No____ If yes how would you like to be contacted: **phone**_____, **email**_____, **letter**_____
Best time of day to reach you_____.

Other Caregiver Information:

Caregiver Role: Role of caregiver in service plan_____

_____

_____

Participant (applicant) will be involved in all scheduled program-activities upon admission including:_____

_____

Participant (applicant) will be excluded from the following groups:_____

_____

Participant/Caregiver signature:_____Date:_____

Staff reviewing applicaiton_____Date:_____

[LEFT BLANK INTENTIONALLY]

Applicant Name _____

GETTING TO KNOW THE PARTICIPANT
Initial Social History

Name:_____

1. Please list the name and relationship of family members and/or friends who are important to the applicant: ____
2. What has been the applicant's education, military service, life work? _____
3. What activities – leisure, vocational, social – has the applicant enjoyed in the past? _____
4. What hobbies or interests does the applicant currently have? _____
5. Where has the applicant lived? _____
6. What customs, foods, religious or cultural observances does the applicant find meaningful? _____
7. How do the caregiver and applicant feel about coming to Adult Day Services? _____
8. In the past, how have the caregiver and applicant coped with challenging situations? _____

9. What losses have the applicant experienced over the past years? (i.e., death, divorce, independence, physical, mental): _____

10. Please describe how the applicant currently spends the day: _____

11. What are the applicants and or caregivers expectations of this program? _____

12. Other facts of interest from the applicant: _____

Person Centered Profile - (applicant's profile)

What is important to me:

What people like or admire about me: (What are my strengths?)

How to support me well:

Completed by _____ Relationship _____ Date _____

Social Worker _____ Date _____