Milton Adult Day Services

Application for Enrollment

Participant Information: Date of Application:_____

Participant's Name_____SS#_____

Address_____City_____State_____Zip_____

Participant's Phone_____Race_____Gender_____Age_____Date of Birth_____

Height_____Weight_____Marital Status_____Primary Language_____

Medicare #_____Medicaid #_____Insurance #_____

Funding Source_____

Living Arrangements: Alone_____W/spouse—Name of Spouse_____

W/adult child—Name of Child_____Other_____

Caregiver Information:

Caregiver's Name_____Relationship_____

Address_____City_____State_____Zip_____

P.O.A._____(Copy attached) Guardian_____Best Daytime Phone_____Email Address _____

Emergency Contacts:

#1 Name_____Relationship _____

Best Daytime Phone_____Cell_____Email Address _____

#2 Name_____Relationship _____

Best Daytime Phone_____Cell_____Email Address _____

#3 Name_____Relationship _____

Best Daytime Phone_____Cell_____Email Address _____

Medical Information:

Physician_____Phone_____Fax _____

Address_____City_____State_____Zip _____

Hospital Preference_____Advance Directives_____Initiate CPR_____No CPR_____

Enrollment Information **Office Use Only**

Intake staff's name/title_____Source of Information _____

Enrollment Date_____Days_____Times_____Transport Mode _____

Referrals To _____

Anticipated Duration of Services _____

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Life History

Please complete this form in as much detail as you can. This information will help us relate to your loved one at our day center. Please return the completed form to the Social Services Coordinator or the Activity Coordinator. Thank you.

Name:_____Wants to be called: _____

Current Significant Other:_____Relationship:_____

Birthday:_____Birthplace:_____

Email Address (you or family)_____Phone No:_____

Growing Up

Childhood city & state: _____

Father's Name:_____Mother's Name: _____

Names of Sisters and Brothers: _____

_____

Ancestors/Immigration: _____

Favorite stories of childhood: _____

Childhood family traditions: _____

Childhood friends:_____Childhood clubs:_____

Childhood pets:_____Religion, if significant:_____

Schooling

Elementary or high school stories: _____

_____

College/trade school: _____

Favorite subjects: _____Favorite sports/games: _____

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As An Adult

Military information: _____

Jobs & careers: _____

Volunteer Work: _____

Marriage: _____

Anniversary:_____Where did you meet? _____

Favorite Entertainment: _____

Number of children:_____Grandchildren:_____Great grandchildren: _____

Parenthood memories: _____

Do you have pets?_____Do you still drive? _____

Do you belong to any clubs or organizations? _____

Most memorable experiences: _____

Favorite family traditions: _____

Travel: _____

Things you enjoyed in the past: _____

_____

What do you usually do each morning? _____

_____

What do you usually do each afternoon? _____

_____

What do you usually do each evening? _____

Contributor:_____**Date:** _____

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Service Contract

Date:_____

Participant Name: _____

The client's level of functioning is: _____

Attendance Schedule Days: _____Times: _____

Who is allowed to pick up participant? _____

Cost of Care/rate – Up to 5 hours in one day = $75.00
Each additional 15-minute increment is $3.75

Billing/Payer Source and Responsible Party

☐ Private Pay ☐ C.H.O.I.C.E. ☐ Medicaid Waiver ☐ Long-Term Care Insurance
☐ Veteran's Administration ☐ Social Security/Pension ☐ Other_____

Responsible Party Name_____Relationship_____
Address_____City_____
State_____Zip_____Phone #_____
Place of Employment_____Phone #_____

Identify three services and priorities that are important to you:

1._____**2.**_____**3.** _____

Hospital Preference: _____
Physician's Name:_____**Phone #:** _____

Prior to enrollment I have received or verified information on the following as:

Release Forms:

Notice of Privacy received and reviewed: Initial: _____

Participant Rights received and reviewed: Initial: _____

Enrollment Criteria received and reviewed: Initial: _____

Discharge Criteria received and reviewed: Initial: _____

Complaint/Grievance received and reviewed: Initial: _____

Photo release: Yes ☐ No ☐ (For the purpose of Client's chart ID & emergencies, internal bulletin board)

Promotion Agreement & Publicity Release Form: Yes ☐ No ☐ (please sign enclosed release form)

Van (or other Outings): Yes ☐ No ☐

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Fees do not include:
The responsible party is accountable for payment of additional days, hours, or transportation charges that are not approved by government funding sources; personal expenses, such as showers or shaves; and outing expenses (admission fees, special food, personal purchases of souvenirs).

Release of Claims for Damages/Losses:
This facility assures that all precautions will be taken to ensure Participant's welfare. The facility discourages Participants from bringing/wearing valuables while attending. The client/responsible person, their heirs and executors waive and release all rights and claims for damages and/or losses that they may have against Milton Adult Day Services (Milton ADS) and their respective directors, officers and agents in which the Participant/responsible person participates.

Initial: _____

In Case of Emergency
In case of emergency, Milton ADS staff/employees may summon/perform emergency services for the Participant and or arrange transportation to the hospital of caregiver/Participant's choice or that is most available. Release of physician's form and application of enrollment will be sent with Participant to expedite admission. By signing, caregiver/Participant understands that such emergency, hospital, or physician services will be billed directly to them and that Milton ADS will not be held responsible for payment of such services.

Initial: _____

If no, list other instructions: _____

Release of Medical Records:
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about this Participant. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by verbal or written request to the Director. You have the right to request that we restrict how protected health information about this Participant is used or disclose for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about this Participant for treatment, payment, or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

Initial: _____

Authorization for Dispensing of Medication:
Medications which have been prescribed by a physician will be given at Milton ADS. Non-prescription medications, i.e. Aspirin, Tylenol, Imodium and antacids may be given as needed according to label directions if we have a signed authorization from the Participant's physician or caregiver.

Medications must be properly identified by **Milton ADS nurse** before they will be given. Upon new/change in medication or initial enrollment, caregivers are required to complete the Authorization for Dispensing form or present medication in its original container (**must be labeled with medication name and dosage)**.

I have read and agree with all the information given and the conditions of this service contract as written.

_____ _____ _____
Responsible Party Signature Relationship Date

_____
Social Services Director

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Promotion Agreement and Publicity Release Form

Location: _____ **Date:** _____

Story/Interview _____ **Photographs** _____ **Video** _____ **Other** (please describe) _____

Individual(s) Participating: _____

I/we have participated as indicated above, which I/we understand is for promotional and/or publicity purposes to be used by Milton Adult Day Services.

I/we agree that insofar as I/we are concerned, the promotional material described above may be edited as desired and used in whole or in part for publication, for broadcasting purposes, for audio and/or visual cassette and closed-circuit exhibition purposes and all other broadcast or printed purposes in any manner or media. I consent to publication and reproduction of any story/interview in whole or in part, including after-broadcast transcripts, and consent to use of my name, likeness, voice and biographical material about me in connection with publicity for or about the promotional material and for institutional purposes as well.

I/we expressly release Milton Adult Day Services, its licenses, and assignees, from any privacy, defamation or other claims I/we may have arising out of publication, exhibition, or broadcast of the above-described promotional material.

I/we also agree to release Milton Adult Day Services, its directors, officers, employees and volunteers from any and all liability, causes of action, claims, demands, or suits whatsoever relating to personal injury to myself/ourselves or damage to my/our personal property which I/we may now have or hereafter have to claim to have, on account of, or arising out of my/our participation in the above-described promotional material.

I/we have not been, nor do we expect to be, compensated for my/our participation in any way, now or in the future.

This publicity release and indemnity agreement shall be construed in accordance with the laws of the State of Indiana and shall be binding upon and insure to benefit of the parties hereto, their successors, assigns, personal representatives, and heirs.

Signature: _____ Date: _____

Signature: _____ Date: _____

Milton Adult Day Services

Memorandum of Understanding

This Memorandum of Understanding is to confirm and specify the nature and extent of the services we will provide. To ensure an understanding of our mutual responsibilities, we ask all families and/or caregivers of **Milton Adult Day Services** participants to confirm the following arrangements.

Our goal is to provide a safe and secure environment, structured activities, health monitoring, and meals for participants of **Milton Adult Day Services**. Semi-annual progress reports will beprovided to update families and/or caregivers of changes in the participant's care plan.

By signing this Memorandum of Understanding, you hereby confirm that you will escort or provide an escort for the participant to safely enter and exit the building if the participant is unable to enter and exit the building safely on their own.

The undersigned family or caregiver agrees to notify the Milton Adult Day Services Director, Nurse, or Social Services Coordinator promptly of any change in the participant's care needs, including but not limited to health, risk of falling, mental or behavioral health, and diet.

The undersigned family or caregiver agrees to notify **Milton Adult Day Services** 24 hours in advance of cancellations of the client's scheduled service days. In the event of a client having poor health that prevents them from attending on a scheduled day, we request notification as early as possible.

We want to express our appreciation for the opportunity to work with you and the participant.

Sincerely,
Milton Adult Day Services

Accepted by:

Signature:_____Date:_____

Responsible Party For: _____
(Participant's Name)

Signature:_____Date:_____
(MiltonADS Staff)

_____
Title

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Notice of Privacy Practices

Consent to Release Medical Information/Records

A Consent to Release Medical Information/Records form should be completed by the client or other authorized person when confidential medical information is requested. Form is attached.

Confidentiality

1. Participant records including background, medical and mental health information will be kept in a locked file cabinet.

2. New employees, consultants, volunteers, and students will be instructed on Milton Adult Day Service's information and written documentation. Only authorized individuals access to records including the person receiving care, a legal guardian, a duly appointed personal representative of a deceased adult, contracted medical professionals working for Milton Adult Day Services, professional consultants, individuals employed or volunteering who are directly involved with individual care, individuals who have been assigned to participants in a professional capacity, such as caseworkers, and local or state inspectors.

3. All persons having access to records will be instructed that revealing information to an improper party is an Invasion of Privacy.

4. Discrimination based on a participant's medical condition is prohibited.

5. Participant charts are not to be left where unauthorized individuals have access to them.

6. Only supervening public or private interest can override this policy and with the Adult Day Services Director's expressed approval. Examples of supervening public and private interests include epidemiology or a missing person.

_____

Client or authorized representative *Date*

_____

MiltonADS Representative *Date*

Milton Adult Day Services

TB SCREENING INFORMATION

Last Name	First Name	Middle
Home Phone	**Cell Phone**	**Email Address**
Address		
City	**State**	**ZIP Code**
Family Physician		

TB Skin test, Mantoux, PPD, 5TU intermediate strength (results at 48-72 hours)

Date Given: _____ Site Placed: _____ Lot #: _____ Exp. Date: _____

Administrator's Signature: _____

Date Read: _____ Results: _____ mm Read by: _____

TB Questionnaire Given (date) _____

Date of Chest X-Ray: _____ Results: _____

Note: If you have a chest x-ray, we will forward a copy of the results to your family physician.