ADULT DAY of DUNWOODY

1 Dunwoody Park South, Suite 123
Dunwoody, GA 30338
P: (770)551-2722 FAX: (866)857-8655

MEMBER INFORMATION

Please bring this form ***completed*** to your scheduled assessment

DATE: _____

NAME: _____ NICKNAME: _____

BIRTHDATE: _____ AGE: _____ PHONE: _____

ADDRESS: _____

CITY: _____ ZIP: _____ COUNTY: _____

DOES APPLICANT LIVE ALONE? ☐ YES ☐ NO IF NOT WITH WHOM? _____

TWO LOCAL EMERGENCY CONTACTS ON FILE:

1. Name: _____ Relationship: _____
   Phone (W): _____ (H) _____
   Cell Phone: _____ Email: _____

2. Name: _____ Relationship: _____
   Phone (W): _____ (H) _____
   Cell Phone: _____ Email: _____

****

SOCIAL SECURITY#: _____ MEDICARE#: _____

PRIVATE INSURANCE NAME: _____ PRIVATE INSURANCE#: _____

MEDICAID#: _____

****

PHYSICIAN'S NAMES/ADDRESSES/PHONE #/FAX #: (PLEASE LIST ALL)

_____

_____

_____

DATE APPLICANT LAST SAW PHYSICIAN: _____

DATE OF LAST HOSPITALIZATION: _____

REASON FOR HOSPITALIZATION: _____

HOW MANY TIMES APPLICANT HAS BEEN HOSPITALIZED LAST YEAR: _____

HOSPITAL REFERENCE: _____

REASON FOR PARTICIPATION IN PROGRAM: _____

MEMBER'S FEELING ABOUT THE PROGRAM: _____

WHERE DID MEMBER LIVE MOST OF HIS/HER LIFE? _____

PARENTS NAME: _____

SIBLINGS NAME: _____

RELIGION: _____ SCHOOL ATTENDED: _____

LAST GRADE COMPLETED: _____ FORMER OCCUPATION: _____

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED ☐ NEVER MARRIED

DATE OF MARRIAGE: _____ NAME OF SPOUSE: _____

CHILDREN'S NAMES: _____

GRANDCHILDREN'S NAMES: _____

HOBBIES/SPECIAL INTERESTS: _____

_____

DOES MEMBER SMOKE: ☐ YES ☐ NO IF SO, HOW MUCH: _____

IS MEMBER ABLE TO READ AND WRITE: ☐ YES ☐ NO

PRIMARY LANGUAGE: _____ OTHER LANGUAGES SPOKEN: _____

ALL OF THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE OF MEMBER OR RESPOSIBLE PARTY: _____

PHONE: _____ DATE: _____

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Physician's Evaluation Form or The Most Current H&P (preferred)

NAME: _____ BIRTH DATE: _____

ADDRESS: _____ PHONE: _____

_____

Diagnosis, chronic illnesses and impairments: _____

_____

*BP: _____ *Pulse: _____ *Weight: _____

Medications	Dosage	Frequency

Can client administer own medication? ☐ YES ☐ NO

If no, please comment: _____

Date of last Tetanus Toxoid (within last 10 years): _____

Allergies (food, drug, or NKA): _____

May applicant take 1-2 tablets of Tylenol q4 hrs/prn? ☐ YES ☐ NO

May applicant take Maalox 30 cc/Tums 1-2 q4 hrs/prn? ☐ YES ☐ NO

TB test result: ☐ Negative ☐ Positive Date: _____

(All prospective clients must have a current TB test before admission to the Adult Day of Dunwoody.)

Diet (Please ***check*** *appropriate diet* for this client):

☐ Regular ☐ Low Cholesterol ☐ Low Salt ☐ 1500 Calorie/Diabetic

SpecialConsiderations/Precautions/Comments: _____

_____

I hereby certify that the above day service plan is medically necessary and is approved by me:

_____

Physician's Name (PRINT)

_____ _____

Physician's Signature Date

_____ _____

Physician's Address Phone Number

*Please complete all items to expedite initiation of services. Thank you.

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_____ Therapy Service (provided on-site PT, OT, Speech) Medicare/Private Insurance/Private Pay

_____ Deposit Secured By:_____ Date: _____

A deposit of $500 will be due by the clients start date along with the $95.00 Intake fee. The $500 Security deposit will be refunded within 30 days of a client's discharge, or transition to another setting.

All invoices are due on the 1st. All invoices will be late on the 10th, with a late of $50 above $500, or 10% of statement if less than $500. Client will not be allowed to return if payment is not received by the 20th, until settled up.

Discharge procedures will be initiated by the Center should the level of care needed by the participant increase beyond that which the Center staff can provided or should the behavior of the individual become disruptive or inappropriate for an adult day center. The family will be consulted and assistance given in making other arrangements. The Center will notify family by phone or in person and with a written notice of 30 days before discharge will take place, except in cases that involve extreme safety issues that require immediate dischai-ge. For voluntary discharge from Adult Day, family/ responsible party must give at least 30 days in advance notice to Adult Day of Dunwoody necessary to receive your security deposit.

Agreed this day _____

Member or Representative Signature _____

Agency Representative _____

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PARTICIPANT RIGHTS

The following rights shall be guaranteed and cannot be waived by the member or his/her representative:

- The right to be treated as an adult, with respect and dignity.
- The right to participate in a program of services and activities that promotes positive attitudes on one's usefulness and capabilities.
- The right to be free from physical, mental, sexual, verbal abuse, neglect, and exploitation.
- The right to be free from actual or threatened physical or chemical restraints.
- The right to be encouraged and supported in maintaining one's independence to the extent that conditions and circumstances permit, and to be involved in a program of services designed to promote personal independence.
- The right to self-determination within the day setting, including the opportunity to:
    1. Participate in developing one's plan of care.
    2. Decide whether or not to participate in any given activity.
    3. Be involved to the extent possible in program planning and operation.
    4. Refuse to participate in treatment, activities or services at the center.
    5. The right to be cared about in an atmosphere of sincere interest and concern in which needed support and services are provided.
    6. The right to privacy and confidentiality.
    7. The right to be made aware of the grievance process.
    8. The right to file a complaint with the Healthcare Facility Regulation Division, including the complete address and phone number of the Division, whenever the participant believes that services are not being delivered in accordance with these rules.
    9. The right to view inspection reports on the facilities compliance on the Departmenfs web site; and
    10. The right to review personal records.

- Each participant shall be provided at the time of admission a copy of the participant rights. Each
- participant shall receive care and services which shall be adequate, appropriate, and in compliance with applicable state laws and regulations.

_____ _____

Participant/Responsible Party Signature Date

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MEDIA RELEASE

Adult Day of Dunwoody often receives requests from the media to take pictures/videos of participants which may be distributed to the public. If you would allow your picture or that of your family member to be released to the public, please check one of the options below and then sign below.

☐ I APPROVE FOR MY PHOTO TO BE RELEASED TO THE PUBLIC.

☐ I DO NOT PROVIDE APPROVAL FOR MY PHOTO TO BE RELEASED TO THE PUBLIC.

_____ _____

Signature of Participant or Responsible Representative — Date

Please Acknowledge the Following regarding Holidays

HOLIDAY NOTICE

In general, The Adult Day of Dunwoody is closed on the following 7 dates and US Holidays.

MONTH	CLOSED
January 2023	New Year's Day / Monday, January 2
May 2023	Memorial Day / Monday, May 29
July 2023	Independence Day / Tuesday, July 4
September 2023	Labor Day / Monday, September 4
November 2023	Thanksgiving & Day After Thanksgiving / November 23 & 24
December 2023	Christmas / Winter Holiday / Monday, December 25

CLOSURE NOTICE

Should the center close for any other reason such as bad weather or otherwise - you will be reached by a Center staff member by phone, text or email as soon as reasonably possible. Should you be unsure if the center is ever open please call the center clarification. We will notify families 30 days in advance of any additional closing.

** It is likely that if DeKalb County Schools are closed or there is a Travel advisory in the case of extreme bad weather (ice and snow) the center would also be closed.

_____

Signature of Responsible Party

_____

Date

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AUTHORIZATION OF DISCLOSURE: MEDICAL CARE

Authorization of Disclosure regarding medical care is requested for the purpose of evaluation, treatment and coordination of services between the medical doctor/providing clinic/hospital and Adult Day of Dunwoody

CLIENT NAME: _____

NAME OF DOCTOR and/or PROVIDER CLINIC: _____

DATE OF AUTHORIZATION: _____

I authorize Adult Day of Dunwoody Service to exchange the following information with my medical provider.

REASON FOR AUTHORIZATON OF DISCLOSURE:

In order to exchange information about medical condition(s); In order to provide appropriate medical care for me; In order to exchange information about my medications; In order to get results of medical testing; In order to assure continuity of care

INFORMATION TO BE DISCLOSED FROM THE DOCTOR'S OFFICE TO ADULT DAY OF DUNWOODY:

General Medical Conditions and Concerns; Change in medical status or presenting symptoms; Medical Diagnoses; Medical History; Prescribed Medications, Refill information; Treatment recommendations; Progress in treatment; Lab results; and/or other medication information as indicated.

INFORMATION TO BE DISCLOSED FROM ADULT DAY OF DUNWOODY TO THE DOCTOR'S OFFICE:

General Medical Conditions and Concerns; Change in medical status or presenting symptoms; Request for medication refills; Questions and/or requests re: prescribed medications; Treatment recommendations; Progress in treatment; and/or other information as indicated.

This authorization of disclosure expires on_____ (up to one year from date of this authorization) OR until the authorization is revoked by client, responsible party/guardian. This authorization to disclose information may be cancelled at any time by written notification. This information will not be used for marketing purposes. A photocopy or fax of this authorization shall be considered as effective & valid as the original. If the client and/or responsible party/guardian refuse to consent to disclose information, the consequences are: ☐ **NONE** ☐ **OTHER:** _____

I am aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

Client Signature: _____ Date: _____

Responsible Party: _____ Date: _____

A copy of this authorization to disclose information has been provided to the client/responsible party. ☐ YES

Adult Day of Dunwoody Witness: _____ Date: _____

Adull Day o! Dunwoody s!alf maintains confidentiality of all participants as defined by Administrative Codes, including bu! not lim!led to Section 240.340; 240.1510 (a-1, 2; f-4o;)2401555 (d-11 and 2H): and, Health Insurance Porlabilily and Accounlab11'ly Act (HIPM) of 1996. 45 eFR 164 508. Aulhonty Sec 1171-1179 of SSA (42 use 1320·d- 1329d-8), 262 of Pub L. 104-191, 110 Slat 202·-2031 and sec 264 of Pub. L. 104-191 (,12 use 1320d-2 1101c)

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PARTICIPANT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provide in our notice, the terms of our notice may change. If we change our notice, you may obtain a review copy by asking the Administrator for one.

You have the right to request that we restrict how protected health information about you is used or disclosed 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 you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Participant Name: _____

Participant/Responsible Party Signature: _____

Responsible Party's Name and Relationship: _____

Name: _____

Relationship: _____

Date: _____

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ADULT DAY OF DUNWOODY
REQUEST CONFIDENTIAL COMMUNICATIONS

I, _____ , (Participant/Responsible Party Name), request that Adult Day of Dunwoody communicate with me about the health care provided by the Center only in the following manner: (check all applicable)

- ☐ At home telephone number — Telephone#: _____
- ☐ Work telephone number — Telephone#: _____
- ☐ Cell number — Telephone#: _____
- ☐ E-mail — Email: _____
- ☐ In-Person
- ☐ Mail

Adult Day of Dunwoody is allowed to leave information concerning me or my family member's health needs on the following: (please check only the options where the Weinstein Center is allowed to leave messages)

- ☐ Work voicemail
- ☐ Home answering machine
- ☐ Cell voicemail

In addition to those permitted by law, Adult Day of Dunwoody may communicate with the following individuals regarding me or my family member's condition or course of treatment. (list only those individuals such as other family members, including the partipant, and/or friends that you wish to have open communication with Adult Day of Dunwoody concerning healthcare issues.

Name	Relationship to participant	Telephone#
Name	Relationship to participant	Telephone#
Name	Relationship to participant	Telephone#
Name	Relationship to participant	Telephone#
Name	Relationship to participant	Telephone#

_____ Signature of client or responsible party

_____ Date

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INFORMATION ABOUT ADVANCE DIRECTIVES

WHAT ARE ADVANCE DIRECTIVES?

Advance Directives are documents that state an individual's choices about medical treatment or name someone to make choices about medical treatments for the individual if the individual is unable to make those decisions. Advance Directives are written before the onset of serious illness. The Patient Self-Determination Act required all programs that provide home health care or personal care services and that participate in Medicaid and Medicare programs to have written policies and procedures on Advance Directives. The state of Georgia has two forms of advance Directives the Living Will and the Durable Power of Attorney for Health Care.

WHAT IS A LIVING WILL?

A Living Will is one type of an Advance Directive. A Living Will is a document that is used only when a person has a terminal condition. It instructs the physician regarding decisions to withhold or withdraw certain medical procedures which could be used to prolong life. A Living Will deals with how an individual wishes to be treated when that individual is dying. The living Will allows and individual to die naturally, without death being artificially prolonged by various medical procedures.

WHAT IS A DURABLE POSER OF ATTORNEY FOR HEALTH CARE?

A Durable Power of Attorney for Health Care is another form of Advance Directives. This document allows one to designate a person or persons to make decisions regarding health care when the individual is unable to do so.

AM I REQUIRED TO HAVE ADVANCE DIRECTIVES?

NO. No one is required to have Advance Directives. Each individual has the right to choose whether or not to have Advance Directives.

WHAT ARE MY RIGHTS?

Each individual has the right to refuse my medical or surgical treatment or services that the individual does not wish to receive. Georgia law allows individuals to sign Advance Directives so that the individual's wishes will be followed even if the individual becomes unable to communicate those wishes to the health care provider.

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CAN I BE REFUSED ADMISSION TO ADULT DAY OF DUNWOODY PROGRAM IF I DO NOT HAVE AN ADVANCE DIRECTIVE?

No. Federal law prohibits programs from refusing to admit a client because the client does not have an Advance Directive. However, individuals will be asked if they do have an advance directive and those answers will be documented.

WHERE CAN I GET MORE INFORMTION ABOUT ADVANCE DIRECTIVES?

This information sheet is one way of providing clients with information about Advance Directives. If you would like more information about Advance Directives, you may contact the Division of Aging Services at (404) 657-5319 or an attorney.

ADVANCE DIRECTIVE CHECKLIST

Please read the following three statements. After reading the statements, please write your initials atthe end of each statement.

I. I have been given written materials on my rights to accept or refuse medical treatment and/or services ad on my rights to formulate Advance Directives._____(Client Initials)

2. I understand that I am not required to have an Advance Directive in order to receive services or medical treatment from Adult Day of Dunwoody. _____(Client Initials)

3. I desire that the terms of any Advance Directive that I execute will be followed by Adult Day of Dunwoody. _____(Client Initials)

Please read the following statements and select the ONE that applies to you:

1. _____I have executed an Advance Directive and will provide a copy to Adult Day of Dunwoody. I understand that the staff of Adult Day of Dunwoody will not be able to follow terms of my Advance Directive until I provide a copy of it to the staff.
2. _____I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.
3. _____I have not executed an Advance Directive but would like to obtain additional information about Advance Directives.

_____ _____

Client's Signature or Responsible Party Signature Date

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ADVANCE DIRECTIVE CHECKLIST

Please read the following three statements. After reading the statements, please write your initials at the end of each statement.

1. I have been given written materials on my rights to accept or refuse medical treatment and/or services and on my rights to formulate Advance Directives.
   _____(Client's Initials)
2. I understand that I am not required to have an Advance Directives in order to receive services or medical treatment from Adult Day of Dunwoody
   _____(Client's Initials)
3. I desire that the terms of any Advance Directive that I execute will be followed by Adult Day of Dunwoody.
   _____(Client's Initials)

Please ready the following statements. After reading the statements, please check ONE of the following statements:

1. ____ I have executed and Advance Directive and will provide a copy of Adult Day of Dunwoody. I understand that the staff of: Adult Day of Dunwoody will not be able to follow the terms of my Advance Directive until I provide a copy of it to the staff.

2. I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.

3. _____ I have not executed an Advance Directive but would like to obtain additional information about Advance Directives.

_____

Client's Signature or Responsible Party Signature Date

_____

Witness' Signature Date