INTAKE PACKET

ADULT DAY of DUNWOODY

Date: _____

ADULT DAY OF DUNWOODY SERVICE INTAKE PACKET

Client Name:		**DOB:**
Address:		**Phone:**
City:		**Zip:**
SSN:		**Medicare:**
Medicaid:		**Other Entitlement (specify):**
Living Arrangement:	☐Alone ☐Spouse ☐Partner ☐Adult Child ☐Other (specify): _____	
Marital Status:	☐Married ☐Widowed ☐Single ☐Partner ☐Divorced or Separated	
Race/Ethnicity:	☐White, not Hispanic Origin ☐Black, not Hispanic Origin ☐Hispanic ☐Asian, Pacific Islander ☐American Indian ☐Other (specify): _____	
Language Spoken:	☐English ☐Spanish ☐Other (specify): _____	
Religion:	☐Jewish ☐Muslim ☐Christian (specify) _____ ☐Other (specify) _____	
Household Income:	☐$0-9750 ☐ $9751-19,570 ☐ $19,751-29,570 ☐ $29,571-50,000 ☐ over $50,000	
Level of Education:	☐0-6th grade ☐ 7-12th grade ☐ Diploma or GED ☐ some college ☐college graduate	
Veteran Status	☐No ☐Yes (if YES, specify which branch): _____	
Former Occupation:		
Current Interests:		

Emergency Information:

(Please check box if this person is authorized to pick up the client from Adult Day of Dunwoody. On the back of this sheet, please list any other people who are authorized to pick up the client)

1st Responsible Person: ☐		**☐Relationship:**
Address:		**Zip Code:**
Home Phone:	**Cell phone:**	**Work Phone:**
Email:		
2nd Responsible Person: ☐		**☐Relationship:**
Address:		**Zip Code:**
Home Phone:	**Cell phone:**	**Work Phone:**
Email:		
Primary Care Physician		**Phone Number:**
Physician Address:		OTHER (SPECIFY):
BILLING SENT TO:	☐Billing set to participant ☐ 1st Responsible person ☐ 2nd Responsible Person Other (specify below):	Relationship:
BILLING ADDRESS:		

Office Use Only: Date form reviewed_____ Date service started: _____ Funding_____ Site attending _____ Days attending _____ Transportation:_____
Safe Return Sent _____ Date discharged: _____ Reviewed by: _____ **HSI - F R P sent VNA Y N**

ADULT DAY of DUNWOODY

AUTHORIZED PERSONS FOR PICK UP

The following persons are authorized to pick up ______________________________ from Adult Day of Dunwoody:

NAME:		**RELATIONSHIP**
ADDRESS:		
HOME PHONE: ____________________	**CELL PHONE:** ____________________	**WORK PHONE:** ____________________
NAME:		**RELATIONSHIP**
ADDRESS:		
HOME PHONE: ____________________	**CELL PHONE:** ____________________	**WORK PHONE:** ____________________
NAME:		**RELATIONSHIP**
ADDRESS:		
HOME PHONE: ____________________	**CELL PHONE:** ____________________	**WORK PHONE:** ____________________
NAME:		**RELATIONSHIP**
ADDRESS:		
HOME PHONE: ____________________	**CELL PHONE:** ____________________	**WORK PHONE:** ____________________

Alzheimer Association's 'Safe Return Program'

'Safe Return' is a nationwide ID, support & registration program. It provides assistance if a person becomes lost locally or far from home. Assistance is available 24/7, whenever a person is lost or found. There is a registration fee.

Is this client registered with the Alzheimer Association's 'Safe Return Program'? ☐ Yes ☐ No
If not, would you like information on the 'Safe Return Program'? ☐ Yes ☐ No

ADULT DAY of DUNWOODY

Medical Information and Permissions

Participant Name	Date

List all medications taken by the above at home and at Adult Day of Dunwoody, along with the exact dosage and the hour(s) of day the medication is taken.

PLEASE NOTE: In accordance with regulations, any medication dispensed by Adult Day of Dunwoody nurses must be in properly labeled containers. Labels MUST include: the participant's name; doctor's name; medication name; time and amount prescribed. ****NO MEDICATION WILL BE DISPENSED WITHOUT A PHYSICIAN'S ORDER AND PROPER LABELING****

A weekly or monthly supply should be sent to the site, to be refilled as needed.

NAME OF MEDICATION	DOSAGE (EXAMPLE: 300 MG)	TIME OF DAY TAKEN (EXAMPLE: 8 AM & 8 PM)
PLEASE NOTE: DOCTOR ORDERS ARE NEEDED FOR Over-the-counter medications such as Tylenol!		

I grant permission to the Adult Day of Dunwoody nursing staff to dispense any needed and properly prescribed, labeled medication to:

Participant Name _____ Date _____

Signed _____ Relationship _____

The state of Georgia requires written authorization for the dispensing of non-aspirin pain relievers (such as Tylenol) by nursing staff to participants.

I grant permission to dispense a non-aspirin pain reliever to the below named client on an as needed basis to:

Participant Name _____ Date _____

Signed _____ Relationship _____

Please note: If a laxative has been given at home, the participant should not return to Adult Day of Dunwoody until the laxative has taken effect, to avoid the embarrassment of bowel incontinence at the center.

Adult Day of Dunwoody Adult Day Service
One Dunwoody Park #123 • Dunwoody, GA 30338 • P: 770.551.2722 • F: 770.551.2729

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 fo 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: _____

Adult Day of Dunwoody staff maintains confidentiality of all participants as defined by Administrative Codes, including but not limited to Section 240.340; 240.1510 (a-1, 2; f-4o;)240.1555 (d-1l and 2H); and, Health Insurance Portability and Accountability Act (HIPAA) of 1996. 45 CFR 164.508. Authority Sec 1171-1179 of SSA (42 USC 1320-d-1329d-8), 262 of Pub. L. 104-191, 110 Stat 202`-2031 and sec 264 of Pub. L. 104-191 (42 USC 1320d-2 note).

ADULT DAY of DUNWOODY

Adult Day of Dunwoody Adult Day Service

AUTHORIZATION OF DISCLOSURE

Authorization of Disclosure is requested for the purpose of evaluation, treatment and coordination of services between service providers, community providers, family members, medical doctor/providing clinic, funding agencies, other identified parties and Adult Day of Dunwoody.

CLIENT NAME: _____

NAME OF INDIVIDUAL/AGENCY: _____

DATE OF AUTHORIZATION: _____

I authorize Adult Day of Dunwoody Service to exchange the following information with the identified individual or agency.

REASON FOR AUTHORIZATON OF DISCLOSURE:

☐Assure continuity of care
☐Address treatment issues
☐Request refills
☐Treatment recommendations
☐Other:

☐Address transportation issues
☐Address scheduling issues
☐Coordinate services between providers
☐Progress in treatment

INFORMATION TO BE DISCLOSED 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; transportation needs; funding needs; progress in treatment; issues related to continuity of care; and, specific information as indicated.

INFORMATION TO BE DISCLOSED FROM ADULT DAY OF DUNWOODY:
General Medical Conditions and Concerns; Change in medical status or presenting symptoms; Prescribed Medications, Refill information; Treatment recommendations; Progress in treatment; transportation needs; funding needs; progress in treatment; issues related to continuity of care; and, specific 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: _____

Adult Day of Dunwoody staff maintains confidentiality of all participants as defined by Administrative Codes, including but not limited to Section 240.340; 240.1510 (a-1, 2; f-4o;)240.1555 (d-1I and 2H); and, Health Insurance Portability and Accountability Act (HIPAA) of 1996. 45 CFR 164.508. Authority Sec 1171-1179 of SSA (42 USC 1320-d-1329d-8), 262 of Pub. L. 104-191, 110 Stat 202`-2031 and sec 264 of Pub. L. 104-191 (42 USC 1320d-2 note).

EMERGENCY MEDICAL CARE

I grant permission to Adult Day of Dunwoody Service to obtain emergency medical treatment for if deemed necessary by the staff in charge.

Client Signature: _____ Date: _____

Responsible Party: _____ Date: _____

ALLERGIES

Please list any food, medication or other allergies:

Please list any other medical information that would help us work better with the participant:

Waiver of Responsibility

I waive the Lifescape Adult Day of Dunwoody Service staff and assistants of all responsibility in case of accident, injury, illness or loss of property.

_____ _____

Signature of Participant or Responsible Representative

Date

Emergency Pick-Up

Adult Day of Dunwoody has trained personnel, including nurses, who strive to act in the best interest of the participants. Occasionally, a participant may become too ill to complete the day or may become too disruptive to remain in the center. If either occurs, the staff may need to call the family/caregiver to pick him/her up.

I agree to pick up _____ if the staff determines it necessary.

I will make alternate arrangements for emergency pick-up on days I might not be easily reached.

I further agree to inform Adult Day of Dunwoody staff of any situations or occurrences, which may affect the participant's behavior while at the center.

_____ _____

Signature of Participant or Responsible Representative

Date

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

Hours of Service Calendar Signature Verification Form

The Hours of Service Calendar documents the dates and hours of each participant's attendance at Adult Day of Dunwoody. It is signed by the participant and a staff person on the last day of each month. If a participant is absent or otherwise unable to sign at that time, this form gives permission for a designated staff person to sign for him or her. In the event of the above named person's absence or inability to sign the Hours of Service calendar, I herby grant permission for a Brightside staff person to sign in his/her place.

_____ _____

Signature of Participant or Representative — Date

_____ _____

Signature of Adult Day of Dunwoody Staff Person — Date

Please Acknowledge the Following regarding Holidays and Refunds

HOLIDAY Notice
The Adult Day of Dunwoody is Closed on the Following 7 Dates and US Holiday's
New Years Day - Memorial Day - July 4th - Labor Day
Thanksgiving and the Day After Thanksgiving and Christmas Day

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 for clarification.

** 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.

OVERPAYMENT REFUNDS
The Adult Day will refund any outstanding overpayment, if applicable, within 60 days of the written to notice of discharge by the client, responsible party or Power of Attorney.

_____

Signature of Responsible Party

_____

Date

ADULT DAY of DUNWOODY

Adult day of Dunwoody Adult Day Service

TRANSPORTATION REQUEST FORM

Please complete this form and return to Adult Day of Dunwoody as part of the Intake Process OR upon request.

Client name: _____

Address: _____

Phone Number: _____

Days of Service (circle all that apply) M T W TH F

Special needs of client (check all that apply): ☐Wheelchair ☐Walker ☐Oxygen ☐Other

Can client be dropped off at home if no one else is present? ☐YES ☐NO

Special instructions for pick up/drop off: _____

Does the client/family have a dog? ☐YES ☐NO

Does client/family agree with dog policy in this intake packet? ☐YES ☐NO ☐ N/A

Is the client subject to (check all that apply): ☐Seizures ☐Wandering

☐Other (explain): _____

I have read the information regarding Adult Day of Dunwoody Transportation and agree with the policies and procedures described. I understand that the pick up and drop off times will fluctuate per route, that the client must be ready when the ADS bus arrives and when it returns at the end of the day. I UNDERSTAND THIS IS A CURB-TO-CURB service and that the ADS Bus Driver cannot help the client to/from the bus. I have been alerted that family and/or caregiver are responsible for ensuring client's ability to get to/from living environment to bus. I understand that if there are obstacles or dangers, the ADS bus will not provide transportation services. Such dangers include but are not limited to ice, snow, physical & structural obstacles, dogs, threatening environment. I understand that ADS transportation may be discontinued for reasons including but not limited to failure to be ready when bus arrives; failure to follow Curb-to-curb policy; failure to have responsible party at home for drop-off. I agree to contact Adult Day of Dunwoody if the client will not be in attendance so bus service may be canceled at the time of the absence.

SIGNED: _____ DATE: _____

RELATIONSHIP TO CLIENT: ☐ SELF ☐FAMILYCAREGIVER ☐GUARDIAN ☐ OTHER: _____