

# APPLICATION FOR ENROLLMENT

## Adult Day Health Care Services

Applicant's Full Name \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_

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### INFORMATION ABOUT APPLICANT:

Why are you interested in coming to this program? \_\_\_\_\_

Have you had previous experience in a day program?  Yes  No

If yes, where and when? \_\_\_\_\_

Marital Status:  Married  Single  Separated  Widowed  Divorced

Present Living Arrangements:  With Relatives  With Non-relatives  
 Alone in Home  Alone in Single Room

Presently Living With: \_\_\_\_\_ Relationship: \_\_\_\_\_

If employed, where: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Nearest Responsible Relative: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email Address: \_\_\_\_\_

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### EMERGENCY CARE INFORMATION:

Please list the names of two persons who may be contacted in case of emergency:

(1) \_\_\_\_\_  
Name Relationship to Applicant

\_\_\_\_\_ Telephone Number  
Address, City, Zip

(2) \_\_\_\_\_  
Name Relationship to Applicant

\_\_\_\_\_ Telephone Number  
Address, City, Zip

Name of Physician : \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_

Hospital of Preference: \_\_\_\_\_

Durham Center for Senior Life  
COMMUNITY LIFE ADULT DAY HEALTH CARE CENTER  
406 RIGSBEE AVENUE, SUITE 102, DURHAM, NC 27701  
TEL 919-682-0215 FAX 919-688-5648

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**SERVICES:**

Transportation will be provided by:  Relative/Friend \_\_\_\_\_  
Name  
 Public Transportation  
 Other

Arrival Time: \_\_\_\_\_ Departure Time: \_\_\_\_\_

Do you have special dietary needs? \_\_\_\_\_

Does participant administer own medication? \_\_\_\_\_

Will staff need to monitor medications at prescribed times? \_\_\_\_\_

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**BILLING INFORMATION:**

Participation in this program will be paid for by:  Myself  Relative \_\_\_\_\_  
 Department of Social Services  
\_\_\_\_\_  
Authorizing Worker's Name /phone #  
 Other  
\_\_\_\_\_  
Indicate Arrangements

The program 's policies and charges have been explained to me and I have received a copy of the policy statement, including participant rights and advanced directives policy. I understand that I am responsible for any charges not covered or authorized by third party payer.

\_\_\_\_\_  
Responsible Party Signature Date

If Paying Privately, please indicate billing name and address below:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Who may we thank for telling you about our program? (list name, address, phone# if known)

\_\_\_\_\_  
\_\_\_\_\_

**RELEASES:**

**EMERGENCY CARE**

If emergency care becomes necessary, I give permission for any treatment the physician deems necessary. I understand that the program will secure emergency services through the 911 system. Information on file regarding Living wills, Health Care Power of Attorney, etc. will be made available to emergency personnel. CPR will be initiated unless a properly certified "no code" document is on file in the program.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant

**NEWSLETTER PARTICIPATION**

I give my permission for general information volunteered by me (or my family member) to be used in the DCSL newspaper, website, or the Center calendar/newsletter. I understand that the papers will be distributed locally in the community or to family members of participants for the purposes of information and public relations regarding the Community Life Adult Day Health Care.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

**PHOTOGRAPH RELEASE**

I authorize the use of photographs taken of me during program activities to be used for the purposes of identification, information, and public relations regarding the Community Life Adult Day Health Care Center. I understand that the participant's verbal consent will be requested before the pictures are taken. Photographs may also be used on the Council's website.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

**FIELD TRIPS**

Community Life Adult Day Care Program has my permission to transport this participant on field trips, and to and from facility as needed. I will be notified of each field trip in advance.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

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## MEDICATION AUTHORIZATION

I hereby authorize the personnel of the Community Life Adult Day Health Care Center to administer the medicines listed below. In doing so, I release the Durham Center for Senior Life, its officers, staff, and personnel from any and all liability that might arise as a result of said medication being administered to (participant name), \_\_\_\_\_ and hereby waive any action which I may have as a result of the medication being administered. I also understand that it is my responsibility to notify the Health Care Coordinator or Director of any changes regarding these medications.

**Please note that ALL medications and over-the-counter medications MUST be in a pharmacy labeled bottle with the prescribing Doctor's Name, Medication Name, and Dosage Information in order for them to be kept at the program.**

**Medication**

**Dose**

**Frequency**

Medication	Dose	Frequency

**RESPONSIBLE PARTY**

**SIGNATURE:** \_\_\_\_\_

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DATE: \_\_\_\_\_

## ADULT DAY HEALTH CARE MEDICAL EXAMINATION REPORT

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_

Most Recent Date Seen by Doctor \_\_\_\_\_

The above named person has applied for, or is enrolled in our adult day health care program. Please complete this form and return it to the program. Your careful examination and written recommendations will help to ensure that the applicant is provided appropriate care and services; will encourage safe participation in adult day health care activities; and will provide a current medical history in case of emergency. Information reported on this form is considered confidential and will be released only with the applicant's written authorization.

1. Does the applicant have any of the following diseases or conditions? If so, please indicate whether or not the condition requires any special attention or restricts normal activities.

CURRENT DISEASE/ CHRONIC CONDITION	YES	Special Attention Required	Restriction on Activities
ANEMIA			
ARTHRITIS			
ASTHMA			
BLINDNESS			
CEREBRAL PALSY			
DEMENTIA – ALZHEIMER’S			
DIABETES			
DIARRHEA			
EMPHYSEMA			
EPILEPSY			
FAINTING SPELLS			
GASTRO-INTESTINAL PROB.			
HEART TROUBLE			
HEARING PROBLEMS			
HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
MENTAL RETARDATION - DOWN’S			
SKIN DISORDERS			
STROKE / PARALYSIS			
TUBERCULOSIS			**PLEASE INDICATE TEST RESULTS
URINARY TRACT PROBLEMS			
OTHER DISEASES NOT LISTED			

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2. Any allergies or reactions to medications? \_\_\_\_\_
3. Receiving any medical treatments? If so, explain. \_\_\_\_\_
4. Does this person have any psychiatric problems?  Yes  No. If yes, please comment on nature, severity, and treatment needs: \_\_\_\_\_  
 \_\_\_\_\_
5. Does this person require constant supervision to make sure he/she does not do harm to self, others, or property?  Yes  No
6. Will this person wander off if not closely attended?  Yes  No
7. Do you recommend any restrictions for medical reasons on physical activities such as walking, exercises, etc.?  Yes  No If yes, please specify:  
 \_\_\_\_\_  
 \_\_\_\_\_
8. Please list all medications the person is now taking, with dosages and times medications are to be taken:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
9. Special diet?  Yes  No If yes, please describe or attach a copy:  
 \_\_\_\_\_  
 \_\_\_\_\_
10. Any other comments? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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 health care activity program.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Licensed Physician or Physician Assistant

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Notice of Privacy Practices (HIPPA)**

### **Acknowledgement of Receipt of Practices**

I have received Center's Notice of Privacy Practices that describes this agency's method for protecting the privacy of my identifiable health information that is used in providing services to me.

I have reviewed this document and have had the opportunity to ask for clarification of anything that I do not understand.

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Applicant signature (or authorized representative)

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Date

This signed and dated receipt to be retained by the Center.

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**ROUTINE STANDING ORDERS**

**MYLANTA – 15 TO 30 CC; every 4 hours PRN indigestion**

**TUMS – Chew 1 to 2 tablets; PRN gas or indigestion**

**TYLENOL TABLET 325 mg. – 1 to 2 tabs every 4 hours PRN pain**

**TYLENOL TABLET 500 mg. – 1 to 2 tabs every 4 hours PRN pain**

**ROBITUSSIN – 1 to 2 teaspoonfuls every 4 to 5 hours PRN cough**

**ANTIBIOTIC OINTMENT – Apply thin film to affected skin tear/abrasion PRN (area may be first cleaned with peroxide, normal saline or betadine)**

**ACCUCHECK – blood sugar as directed by physician and or PRN for s/s of Hyperglycemia**

I understand that these may be administered to \_\_\_\_\_,

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Note: The Adult Day Health Program keeps Tylenol on hand. Please supply the other items that may be needed.**