THINK ABILITY ADULT DAY CENTER
2115 Beech Street Duncan, OK 73533
Phone 580.786.4880 FAX 580.786.4879

INTAKE INFORMATION SHEET

NAME: _____ **Date:** _____
FIRST MI LAST

ADDRESS: _____

City: _____ **State:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

SS #: _____ **DATE OF BIRTH:** ____/____/____ **MARITAL STATUS:** _____

Living Arrangements: [ ] Independent [ ] Caregiver [ ] Other (please explain) [ ] _____

Veteran: [ ] Yes [ ] No Legal Resident: [ ] YES [ ] NO

Physician:
_____

Physicians
Address: _____

Physician's Fax: _____ **Physician's Phone:** _____ **Hospital:** _____

Religious Preference: _____ **Pastor/Church:** _____

RESPONSIBLE PARTY:
Name: _____ Relationship: _____
FIRST MI LAST
Street Address: _____ City: _____ OK ZIP _____

Home #: _____ Work #: _____ Cell Phone: _____

Email: _____ Fax: _____

PRIMARY EMERGENCY CONTACT: (if other than Responsible Party)
Name: _____ Relationship: _____
FIRST MI LAST
Street Address: _____ City: _____ OK ZIP _____
Home #: _____ Work #: _____ Cell Phone/Pager: _____
Email: _____ Fax: _____

OTHER EMERGENCY CONTACTS:
Name: _____ Relationship: _____

FIRST MI LAST

Street Address: _____City: _____St____ Zip_____
Home #: _____Work #:_____Cell Phone/Pager: _____
Email: _____Fax:_____

Name: _____ _Relationship:_____

FIRST MI LAST

Street Address: _____City:_____ St_____ ZIP_____
Home #: _____Work #: _____Cell Phone/Pager: _____
Email: _____Fax:_____

I learned about the Ability First Adult Day Center from: [ ] Media, [ ] Newspaper, [ ] Friend, [ ] Family Member, [ ] Physician,

[ ] Other_____

SAFETY ASSESSMENT WORKSHEET

Name_____ Date_____
FIRST MI LAST

1. Are you having difficulty fastening buttons or snaps on clothing? Y___ N___

2. Do you require assistance when getting dressed? Y___ N___

3. Have you noticed a decrease in arm strength? Y___ N___

4. Are you having difficulty lifting or raising your arms over your head? Y___ N___

5. Are you having difficulty feeding yourself or holding utensils? Y___ N___

6. Are you having difficulty maintaining your balance while standing or brushing your teeth at the sink? Y___ N___

7. Have you recently experienced a decrease in strength, endurance/stamina, or mobility? Y___ N__

8. Do you have difficulty speaking or communicating your needs? Y___ N___

9. Is it difficult to sit on the edge of your bed without falling toward one side or the other? Y___ N___

10. Are you having difficulty getting in and out of shower? Y___ N___

11. Do you have difficulty getting in and out of bed? Y___ N___

12. Are you having difficulty walking or have you had falls recently? Y___ N___

13. When walking, do you require assistance from a walker, cane, etc.? Y___ N___

14. If currently using an assistive device, do you have difficulty getting in/out of a chair? Y___ N___

15. Do you have difficulty using your assistive device? Y___ N___

16. If you use a wheel chair, do you have difficulty transferring to/from: bed, recliner, toilet, etc.? Y___ N___

ADMISSION AGREEMENT

NAME: _____
FIRST MI LAST

Participant's gross monthly income: _____Combined income (if married): _____

Eligible for DHS assistance: [ ] Yes [ ] No Date Filed for DHS Assistance: _____

DHS Case Number: _____ Caseworker: _____

Co-Pay: _____ _____ Number of Days per Month Approved: _____

Medicare Number: _____ A or B Medicaid Number: _____

Insurance Company: _____Policy Number: _____

Responsible Party: _____Relationship:_____
FIRST MI LAST

Address: _____City/State: _____

CHECK ALL THAT APPLY:
[ ] Living Will [ ] Power of Attorney [ ] Durable Power of Attorney [ ] Conservator [ ] Guardian [ ] Do Not Resuscitate

I understand that my attendance is limited by the unity authorized on my plan of care. In the event my plan of care expires or my attendance exceeds the number of units authorized I will be responsible as a private pay attendee.

Private Pay Agreement
I understand that Think Ability Inc. Adult Day is accepting _____as a private pay client for the period of _____, and I will be responsible for paying for any services that I receive. The provider will not file a claim to _____ for the services that are provided to me.

1. COMPENSATION

Regular rate of pay = $_10.00_ per hour; Meals and Snacks available at $6.00 per day.
+ Overtime rate of pay = $_15.00_ per hour (for more than 40 hours in a week)

ADMISSION AGREEMENT

I understand that my acceptance into the Ability First Adult Day Center program is provisional and that I will be evaluated for two weeks by the staff of the Center for appropriateness of this program for me.
Further, I understand that I might not be accepted into the Ability First Adult Day Center program after the provisional period for the following reasons:

1) I do not respond to the program.
2) I have some behavior(s) that interfere with the operation of the program.
3) I experience a physical or mental condition that indicates another level of care is necessary.

I understand that if I have any habit or behavior that is disruptive to the group, my continuance in the program will depend upon my correction of the problem. I understand that the Ability First Adult Day Center and my family will work with me to correct difficulties. I understand that I will be discharged from the program if there is lack of improvement regarding the disruptive behavior or habit.

_____ _____

Date Signature of Participant or Guardian

PARTICIPANTS' RIGHTS

Name: _____
FIRST MI LAST

Each participant of the Ability First Adult Day Center shall be assured of the following rights:

1. To be treated as an adult with respect and dignity regardless of race, color, or creed.

2. To participate in a program of services and activities that promote positive attitudes regarding one's usefulness and capabilities.

3. To participate in a program of services designed to encourage learning, growth, and awareness of constructive ways to develop personal interests and talents.

4. To promote, maintain, and maximize personal independence.

5. To be encouraged to attain self-determination including; opportunity to participate in developing a care plan for services, decide whether or not to participate in any given activity, and be involved in program planning and operations to the fullest extent possible.

6. To be cared for in an atmosphere of sincere interest and concern where needed support and services are provided.

7. To have privacy and confidentiality.

8. To be free of mental and physical abuse.

9. To have access to a telephone to make or receive calls, unless the family indicates necessary restrictions.

10. To be free of interference, coercion, discrimination, or reprisal.

_____ _____

Date Signature of Participant or Guardian

Activities of Interest

Please tell us as much about yourself as possible in order for us to plan programs and activities that interest and benefit you.

Name: _____ **Spouse's name**: _____
FIRST MI LAST FIRST MI LAST

DOB: _____ **Birth Place**: _____

No. of Years Married: _____ **Maiden Name**: _____

Married in: City: _____ State_____

Children (number): _____ **Names**: _____

_____

Places lived: _____

Places traveled: _____

Occupation(s): _____

Activities of Interest:

__ Games __ Pets/Animals __Television __ gardening __ Music __ Arts & Crafts __ Sports __Woodworking __ Handiwork __ Movies __ Exercise __ walking __ Reading __ Museums __ shopping __ Sewing __ Cooking __ puzzles

Others: _____
_____
_____

Clubs, Organizations and Volunteerism: _____

_____

RELEASE OF RESPONSIBILITY

I would like to attend the Ability First Adult Day Center and participate in the regularly scheduled activities. I acknowledge my participation in all activities sponsored by the Day Center is voluntary. I will not hold the Center, employees, or volunteers responsible for any illnesses or accidents that may occur while I am a participant in the program. I understand that any financial liability incurred due to transportation, treatment, or extended care that results in an accident or illness while in attendance at the Ability First Day Center, Inc. is my sole responsibility. I further understand that if I wander away from or leave the facility without consent of the staff, I will not hold the Ability First Adult Day Center, employees, or volunteers responsible for illnesses or accidents that may occur.

_____ _____

Date Signature of Participant or Guardian

ADDITIONAL SERVICES AGREEMENT

As a part of my attendance at the Day Center, I hereby request to have the following additional services provided. I understand that I am fully responsible for the cost of such services and understand that I will be billed separately for these costs by the agency providing the service.

[ ] Physical, Speech, and/or Occupational Therapy Services
[ ] Mental Health Counseling Services
[ ] Home Health Services
[ ] No additional services requested
[ ] Other:

_____

_____ _____

Date Signature of Participant or Guardian

PUBLICITY RELEASE

(Please check one)

[ ] I hereby consent to and authorize the use and reproduction of any and all photographs taken by the Ability First Adult Day Center or its authorized representatives for the purpose of publicity and agree there is no monetary compensation. The photographs and negatives shall remain the sole property of the Ability First Adult Day Center.

[ ] I DO NOT consent to or authorize the use and reproduction of any photographs to be taken of me by the Ability First Adult Day Center or its authorized representatives for the purposes of publicity.

_____ _____

Date Signature of Participant or Guardian

Release of Participant's Information

Participant's Name: _____
FIRST MI LAST

I, _____, as the [ ] participant or [ ] guardian, authorize the
FIRST MI LAST
Ability First Adult Day Center to release Participant information to the following individuals:

_____ _____

_____ _____

I understand that only the above listed individuals will be given Participant information. I understand that I am responsible for keeping this list up to date and do not hold the Ability First responsible if I fail to do so.

_____ _____
Signature of Participant or Guardian *Date*

Leave authorization

I, _____, primary caregiver/guardian for _____ authorize the Ability Adult Day Center to allow the above mentioned individual to leave the Center with the following people:

_____ _____

_____ _____

_____ _____

_____ _____
Signature of Caregiver /Guardian Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____
FIRST MI LAST

Social Security Number: _____

Date of Birth: _____

Your patient, identified above, is interested in attending Ability First Adult Day Center, a non-profit organization that strives to promote independent functioning and social needs of older and handicapped citizens. The structured daytime program provides socialization and life skills through activities, art, health monitoring, and recreational activities under the care of dedicated professionals in a safe and caring environment.

By state law, you must be advised that:

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS INDICATING THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE. THE DISEASES MAY INCLUDE, BUT ARE NOT LIMITED TO, HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNO-DEFICIENCY VIRUS (HIV), ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

I, _____ hereby give consent to
FIRST MI LAST

Dr. _____ (personal physician) and to

_____ (hospital / facility) to release health information to Ability First so the Center might be informed in order to assist with my health care. I understand this consent can be revoked at any time, **except to the extent that disclosures made in good faith have already occurred in reliance on this consent.** All employees, officers, attending physicians, and physicians listed above are released from legal responsibility for the release of the requested information.

Dated this_____ day of _____, 20_____

_____ _____
Signature of Witness Signature of Participant/Caregiver

Consent to Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations

Name of Participant: _____Date of Birth: _____
FIRST MI LAST

I understand that the facility maintains, uses, and discloses personal health information in order to provide for my care and treatment, to arrange for billing and payment for my care, and carry out general management and operations of the facility such as quality review.

I understand that these and other uses and disclosures of my personal health information are described more completely in the facility's Notice of Privacy Practices.

I understand that the facility reserves the right to change its privacy practices described in the Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information already received and maintained by the facility as well as for new information.

I understand that prior to implementation the facility will mail a copy of the revised Notice of Privacy Practices to the address I have provided.

In addition, I understand that I have the following rights:

The right to receive and review the facility's Notice of Privacy Practices before signing this Consent.

The right to request restrictions on how protected health information about me is used or disclosed for treatment, payment or health care operations. The facility is not required to agree to my request, but if it does, it will be bound by its agreement.

The right to revoke this Consent, in writing, except to the extent the facility has acted in reliance on the Consent.

The right to receive a copy of this Consent form.

I consent to the use and disclosure by the Ability First Day Center and its agents or representatives of all my personal health information for purposes of treatment, payment and health care operations.

By signing below, I acknowledge that I have read and understand this Consent form.

_____ _____
Signature of Participant or Participant's Authorized Representative Date

If signed by the Participant's Representative, please print name and describe relationship to participant:

Name: _____ _____
First MI Last Relationship to Participant

MEDICAL HISTORY
COMPLETED BY FAMILY

Name: _____
FIRST MI LAST

List of all Diagnoses: (1) _____ (2) _____
(3)_____ (4) _____
(5)_____ (6) _____

List of all Medications and Allergies:

MEDICATIONS		ALLERGIES
(1)_____	(2) _____	(1) _____
(3)_____	(4) _____	(2) _____
(5)_____	(5) _____	(3) _____
(7)_____	(8) _____	(4) _____

Past Surgeries and Dates:
(1)_____ Date: _____
(2)_____ Date: _____
(3)_____ Date: _____
(4)_____ Date: _____

History of TB /or Positive TB Skin Tests? [ ] Yes [ ] No
At Risk for HIV Infection? [ ] Yes [ ] No
Weight Loss or Gain in the last 6 months? [ ] Yes [ ] No
Is there a DNR (Do Not Resuscitate) Order? [ ] Yes [ ] No

Have you ever experienced any of the following health problems? (Check all that apply)

[ ] Diabetes [ ] Depression [ ] Heart Disease [ ] Heart attack
[ ] Heart Failure [ ] Alzheimer's disease [ ] Stroke [ ] Inability to Speak
[ ] Chronic Lung Disease [ ] High Blood Pressure [ ] Pneumonia [ ] Memory Problems
[ ] Stomach Problems [ ] Paralysis [ ] Bowel Problems [ ] Joint Pain/Arthritis
[ ] Parkinson's disease [ ] Urinary Infections [ ] Diarrhea [ ] Pacemaker
[ ] Dizziness [ ] Osteoporosis [ ] Incontinence [ ] Fractures
[ ] Multiple Sclerosis [ ] Seizures [ ] Skin Problems [ ] Anemia
[ ] Headaches [ ] Constipation [ ] Head Injuries [ ] Thyroid Problems
[ ] Kidney Problems [ ] Cancer – please specify: _____
[ ] Hernias – please specify location: _____
[ ] History of Alcoholism [ ] History of Combativeness
[ ] Other Behavioral Problems: _____
[ ] Other Case Problems: _____

_____ _____
Date Signature of Ability First Adult Day Center RN