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Admission Checklist

We have created a checklist of the required forms for you in an effort to make the admission process smooth & time effective.

For participant review & files:

- Schedule a visit
- Welcome Letter
- Admission Criteria
- Activity Schedule
- Operating Policies

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PRE-ADMISSION

- Statement of Participant’s Rights
- Pre-Enrollment Application
- Functional Assessment Form
- Emergency Contact Information
- Medical Emergency Authorization Form
- Informed consent for photographs
- Authorization to release medical records

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Forms to be completed by Primary Care Physician

- Pre-Admission Physician’s Assessment
- TB/PPD Screening (w/in 30 days prior to admission)
- Physician’s Approval to Administer Medication Form
- DNRO Code form (***print/sign on yellow paper***)
- History & Physical (w/in 6 months)(Obtain copy from MD)

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POST ADMISSION

- Service / Admission Agreement
- New Participant Form
- HIPPA Policy
- Copies of POA
- Copies of Living Will
- Copies of Advance Directives
- Fire Arm Policy
- Harassment Policy
- Financial Questionnaire
- Medical Care Plan
- JTA Application
- Complete MAR
- Add to Daily Attendance Sheet
- Create/Place Sign in Sheet

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Note: An admission meeting will be scheduled with the Director for final review of required forms prior to official enrollment



Dear Friend,

Thank you for your interest in Life's Essence Adult Day Services, Inc. We are delighted to provide you with information about our services and admission process.

Our Day Program is open from 8:00am-5:30pm (Monday - Friday). Extended hours available Mon – Fri 6:30a – 6:30p & Saturdays 8a – 4p. We provide breakfast, lunch, and snacks. We also provide an exciting therapeutic, social, and recreational activities!

LEADS currently does not provide transportation to the program. However, we can assist you with setting up arrangements with JTA paratransit. JTA provides transportation for a nominal fee (for qualified individuals) or a transportation provider of your choice.

The first step in our admission process is scheduling a free visit for a day. We encourage a full day's visit. This allows you to experience the program, interact with our staff and other participants. If you decide to enroll, we would need you to complete our "Enrollment Packet" and a valid government issued photo identification. This packet includes several forms and medical evaluation that need to be completed by your doctor. The doctor's evaluation/assessment must be within 30 days prior to admission into our program. Thereafter, we request medical updates every 12 months while you are enrolled in our center. It is the participant's responsibility to notify the facility Director or Nurse of any medical changes to ensure a complete medical profile.

For your convenience, we have included an "Admission Checklist" and all the required forms for a smooth enrollment process.

If you have any questions or wish to schedule a visit please contact Berline Dorcelus at Leadsvcs@gmail.com or call us at 904-503-2244.

We look forward to hearing from you soon!

Sincerely,

B. Dorcelus, BSN, RN, CDN

Berline Dorcelus, BSN, RN, CDN

Director * Notary Public



Admission Criteria

Applicant will be admitted only after an assessment by the Adult Day Program Coordinators.

- Must be adults with one or several diagnoses affecting cognitive or physical impairment
- Must indicate a willingness to participate in the program.
- Must be functionally challenged, whether due to physical or cognitive conditions.
- Must can benefit from social and therapeutic interaction
- Must not require constant 1 to 1 staff supervision
- Must be ambulatory either with or without the assistance of a wheelchair, cane or walker.
- Must not present a danger to oneself or participants.
- Must can perform activities of daily living without skilled assistance.
- Family members and/or primary caregivers, must be willing to assist client in participating in the program
 - Periodic meetings with staff to review participant's individual care plan when needed.
- We are unable to accept clients that are wheelchair and/or bedbound.
 - Clients that require canes and walkers can be accepted.
 - Clients that dependent of canes/walkers are encourage to bring them each day for safety and independence.
- The family is responsible to provide these devices for their family safety.
 - Participants are required to use the assistive devices upon entering and exiting the Center as a safety precaution.



MAINTAINING INTEGRITY, SAFETY & PEACE of MIND is our primary goal!

ACTIVITY SCHEDULE

<u>TIMES</u>	<u>ACTIVITIES</u>
8:00 a.m.	BREAKFAST CLUB Socialization, puzzles, magazines, books & music will be provided as everyone arrives.
9:00 a.m.	BREAKFAST
10:00 a.m.	MORNING NEWS / READING / DISCUSSION
10:30 a.m.	EXERCISE Light Exercise / Chair Aerobics / Stretching
11:00 a.m.	MORNING GROUP SESSION Activities may vary to include arts, creative/expressive, crafts, cooking, gardening, intergenerational and/or cognitive stimulation discussions, in a group setting. Participants may choose to perform one-on-one activities based on abilities and interests.
11:45 a.m.	Lunch preparation
12:00 p.m.	LUNCH
1:00 p.m.	INDIVIDUAL ACTIVITIES / REST Activities included: reading, reminisce, humor hour, trivia, games, current events, educational activities, puzzles, computer time, music therapy, and discussion topics.
2:00 p.m.	OUTDOORS / DAILY DOSE OF VITAMIN D (depending on weather)
2:45 p.m.	Snack preparation
3:00 p.m.	SNACK
3:30 p.m.	REST TIME
4:00 p.m.	AFTERNOON GROUP ACTIVITIES Activities may include: cognitive, physical, memory games, balloon volley, pampering personal care, sensory stimulation, music therapy, and storytelling
5:00 p.m.	EVENING NEWS



5:30 p.m.

TRANSPORTATION / FAMILY ARRIVES

OPERATING POLICIES

Inclement Weather Closing & Notification Procedure

When it becomes necessary to close Life's Essence Adult Day Services, Inc. the following procedures will be followed.

- LEADS staff will notify each participant/family of closing via one or more platforms. Such as our website, Facebook, Instagram, Twitter, phone, & communication board.
- Early Dismissal – In the case of early dismissal/closure, which is rare, LEADS staff will contact participants/family members by telephone to arrange early pick up.
- LEADS staff will remain on site until all participants have been picked up.
- Life's Essence will automatically close the Duval County Schools close due to inclement weather.
- Although road closings will always mean an automatic program closure, our decision to close at other times will be based on what we determine to be very hazardous driving conditions and concern for safety. Program Fees – There will be no fees billed for inclement weather closings.

Participant Transportation

Arrangements for transportation to and from the adult day program is the sole responsibility of participants and their families. We are more than happy to assist in finding & signing up for transportation services of your choice/qualification.

Our center must have the name(s) and contact information of all transportation company/drivers.

Please include any drivers that might be needed for last minute changes.

Program pickups must occur no later than 5:30p, unless participant has registered for extended evening hours.

Late pickups will result in a verbal warning and possible dismissal from the program.

Participant Absence

In the event, participant will be absent, please contact the Director at 904-503-2244.

The reason for the absence and estimated duration are required to amend scheduled meals, activities, supplies, and staffing.



Payment

Costs of services are paid for by the family or guardian of the participant prior to services being provided.

- Daily payments - Fees for daily drop off / intermittent use are due at the time of services.
- Weekly payments - Fees are due Friday prior to week service will be provided.
- Monthly payment – By the 3rd of each month
- Arrangements for attendance (Drop off / intermittent) must be made at least 24 hours in advance. Availability is limited.

TOPICS COVERED IN SERVICE AGREEMENT

HOURS

SIGN IN/OUT SHEET

MEDICATIONS

FINANCIAL ASSISTANCE

FEES

FOOD SERVICE

PARTICIPANT SUPPLIES

TRANSPORTATION

SOCIAL MEDIA

ATTENDANCE / ABSENCE

EXTENDED ABSENCES

MAKE UP DAYS

LATE PICK UPS

WITHDRAWAL

TERMINATION / DISCHARGE

EMERGENCIES

DISASTER PREPAREDNESS

ADVANCED DIRECTIVES

ASSISTIVE DEVICE

VALUABLES / CLOTHING / PERSONAL BELONGINGS

SMOKING

VISITS

GRIEVANCES

ABUSE AND NEGLECT

GIFTS TO EMPLOYEE

FIELD TRIPS & SPECIAL EVENTS

CANCELLATION/TERMINATION REQUEST



PARTICIPANT'S BILL OF RIGHTS

The Center shall assure that the basic rights of participants are protected always.

The right to participate regardless of race, color or national origin

The right to a safe, secure and clean environment.

The right to be free from harm, including unnecessary physical or chemical restraint, isolation, excessive medication, and related charges.

Each participant shall be treated with respect, consideration, and full recognition of his/her dignity, regardless of handicapping conditions.

The right to be treated as an adult, with consideration, respect and dignity, including privacy in treatment and in care for personal needs.

Each participant shall be informed of the services available to him/her and of the fees for such services.

A summary of available services shall be given to each participant upon enrollment.

Each participant shall be given the opportunity for input into the development of his/her plan of care and offered choices regarding participation in activities and treatment.

The right to voice grievances without discrimination or reprisal with respect to care or treatment that is (or is not) provided.

The right to communicate with others and be understood by them to the extent of the participant's capability.

Each participant shall be free to associate with persons of his/her choice and to communicate privately with them. Assistance shall be given by Center staff as required in the reading and writing of correspondence.

Each participant shall have the opportunity to participate in any activity of the program unless it is medically constrained. No participant shall have his/her constitutional rights abridged because of participation in the program.



**LIFE'S ESSENCE
ADULT DAY SERVICES**

Non-Profit, Inc.

(Participant's Bill of Rights)

The right to participate in a program of services and activities designed to encourage independence, learning, growth and awareness of constructive ways to develop one's interest and talents.

The right to self-determination within the day care setting, including the opportunity to:

- Participate in developing one's plan for services and any changes therein.
- Decide if he/she would like to participate in any given activity.
- Be involved to the extent possible in program planning and operation.
- Refuse treatment and be informed of the consequences of such refusal.
- End participation in the adult day program at any time.

Each participant shall be assured of privacy in the treatment of his/her records. He/she shall sign a release for any information that is disclosed by the Center to any person or agency for any reason, except emergencies.

The right to be fully informed, as evidenced by the participant's written acknowledgement of these rights.

Participant's Signature

Date

Family/Guardian's Signature

Date

Family/Guardian Name Print

Date



**LIFE'S ESSENCE
ADULT DAY SERVICES**

Non-Profit, Inc.

(Participant's Bill of Rights)

APPLICATION FOR SERVICE

Date of Application: _____

Participant Name: _____ Preferred Name _____
Last First MI

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____
Date of Birth: _____ Current Age: _____ State of Birth: _____
Social Security #: _____ Sex/Gender _____ Race/Ethnicity: _____
Marital Status: S M W D Spouse/Significant Other: _____
Religious Preference: _____ Place of Worship: _____
Former Occupation: _____ Military Branch: _____

Children Names _____

Attendance per week: (Circle Days)
Fulltime – 3 or more days Mon Tues Wed Thurs Fri 8a -5:30p
Part time - Less 3 days Mon Tues Wed Thurs Fri 8a -5:30p
Drop Off (minimum 4 hrs.) Mon Tues Wed Thurs Fri 8a -5:30p
Respite (minimum 4 hrs.) Saturday (By Appointment) 8a -4:00p

Extended Hours: Monday – Friday AM: 6:30a – 8a PM: 5:30p – 7:30p Saturday - N/A

Mode of Transport: Drives ___ Family ___ JTA ___ Cab ___ Other _____

SIGN OUT PERMISSION:

Print Name: _____ Relationship: _____ Phone: _____
Print Name: _____ Relationship: _____ Phone: _____
Print Name: _____ Relationship: _____ Phone: _____

Diet (Restrictions) _____
Allergies: _____



PHYSICIAN INFORMATION

Physician: **Primary Care Doctor** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____

Physician: **Dentist** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____

Physician: **Cardiologist** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____

Physician: **Endocrinologist** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____

Physician: **Nephrologists** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____

Physician: **Neurologists** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____

Physician: **Oncologist** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____

Physician: **Surgeon** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____



Physician: Specialist _____ Last Appointment _____
 Name: _____
 Address: _____
 Office #: _____ Fax: _____

Physician: Specialist _____ Last Appointment _____
 Name: _____
 Address: _____
 Office #: _____ Fax: _____

Please indicate any of the following issues that the applicant/participant experiences:

I. ISSUE:

_____ DEMENTIA

Severe _____ Moderate _____ Mild _____

Orientation of time, place and person is accurate

25% _____ 50% _____ 75% _____ 100% _____
 (Severe) (Moderate) (Mild) (All the time)

Behavior Peak Time _____

II. ISSUE:

_____ WANDERING BEHAVIOR.

Includes walking with no purpose, demonstrating a lack of involvement in any activity or conversation.

Behavior is observed (1) _____ Daily
 (2) _____ On occasion w/in each week
 (3) _____ On occasion w/in a month.

This behavior is (a) _____ Easily redirected
 (b) _____ Redirected with effort
 (c) _____ Accelerates to combative/aggressive behavior when redirected.

Specific example(s) _____



III. ISSUE:

_____ AGGRESSIVE BEHAVIOR.

- Includes (a) _____ Refusal to comply with a necessary request
(b) _____ Verbal assault i.e. name calling, use of profanity etc.
(c) _____ Physically pushing, pinching, slapping, scratching, kicking or punching a fellow participant

Specific example _____

- Behavior is observed (a) _____ Daily
(b) _____ On occasion w/in each week
(c) _____ On occasion w/in a month.

- This behavior is (a) _____ Easily redirected
(b) _____ Redirected with effort
(c) _____ Requires physical/chemical restraint.

Specific example _____

IV. ISSUE:

_____ SOCIALLY WITHDRAWN BEHAVIOR.

- Includes (a) _____ Avoidance of conversation
(b) _____ Refusal to participate in activities which require interaction with another person
(c) _____ A lack of eye contact

- Behaviors observed (a) _____ Daily
(b) _____ On occasion w/in each week
(c) _____ On occasion w/in each month

- This behavior is (a) _____ Easily redirected
(b) _____ Is redirected with effort
(c) _____ Has not been successfully redirected.

Specific example _____



I. ISSUE:
 _____ INCONTINENCE

- (1) _____ Occasional (25% of the time or less)
- (2) _____ Partial (25-50% of the time)
- (3) _____ Complete (75%-100% of the time)

Comments _____

II. ISSUE:
 _____ TOILET LEARNING DUE TO DEVELOPMENTAL DISABILITY

III. ISSUE:
 _____ MEDICAL PROBLEMS

Include (circle condition effecting client):

- | | | | | |
|--------------|-----------|-----------|------------------|---------|
| Ambulation | Appetite | Arthritis | Cardiac Diabetes | Hearing |
| Hypertension | Seizure | Speech | Stroke | Vision |
| Weight loss | Alzheimer | Dementia | | |

Any observed indications/symptoms of mental/emotional disorders:

- | | | |
|---------------------|------------------|--------------------------|
| ___ Depression | ___ Anxiety | ___ Withdrawal |
| ___ Paranoia | ___ Hypochondria | ___ Disoriented |
| ___ Confusion | ___ Memory loss | ___ Sense of uselessness |
| ___ Hallucinations | ___ Acting out | ___ Aggressive behavior |
| ___ Sexual Fixation | ___ Hostility | ___ Self-neglect/ abuse |
| ___ Anger | ___ Wandering | ___ Other |

Other health conditions not listed:



IV. ISSUE:

PAST SURGICAL HISTORY

- | | |
|-----------|-------------|
| 1. _____ | Year: _____ |
| 2. _____ | Year: _____ |
| 3. _____ | Year: _____ |
| 4. _____ | Year: _____ |
| 5. _____ | Year: _____ |
| 6. _____ | Year: _____ |
| 7. _____ | Year: _____ |
| 8. _____ | Year: _____ |
| 9. _____ | Year: _____ |
| 10. _____ | Year: _____ |

V. ISSUE:

MEDICATION MANAGEMENT

Medication Administration: Independent _____ Dependent _____ Supervised _____

Medication	Dose	Route	Frequency	Reason/Diagnosis	Start Date	Stop Date
Ex: Tylenol	650 mg	Mouth	Every 4 hours	Pain or Fever	01/01/2017	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						



VI. ISSUE:

LIMITATIONS

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

VII. ISSUE:

ASSISTIVE DEVICE(S)

- A. Ambulatory
 - a. Independent
 - b. Walker
 - c. Cane
 - d. Crutch
 - e. Wheelchair

 - f. Prosthesis
 - i. Left Leg
 - ii. Right Leg
- B. Auditory
 - a. Hearing Aide
 - i. Left Ear
 - ii. Right Ear
 - iii. Both Ear
- C. Visual
 - a. Glasses
 - b. Contacts
 - c. Prosthesis

Comments _____

VIII. OTHER ISSUES/CONCERNS:

- A. _____
- B. _____
- C. _____
- D. _____



Please sign the Consent/Authorization for the Release of Confidential Information if requested.

Please include an Application Fee of \$75 (non-refundable fee) with this application. The Director will contact you after this application has been reviewed.

Signature of Applicant or Guardian Completing Application

Date

If the applicant has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the applicant: _____



FUNCTIONAL ASSESSMENT FORM

Date of Application: _____

Participant Name: _____ Preferred Name _____
 Last First MI

Address: _____
 Street City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____
 Date of Birth: _____ Current Age: _____ State of Birth: _____
 Social Security #: _____ Sex/Gender _____ Race/Ethnicity: _____
 Marital Status: S M W D Spouse/Significant Other: _____
 Religious Preference: _____ Place of Worship: _____
 Former Occupation: _____ Military Branch: _____

Living Arrangements

of people/family members at Home: _____

Name: _____

Relationship: _____

Family members living nearby: _____

Frequency of contacts:	By phone	Visits
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Past Work Experience: _____

Educational Background: _____

Special Skills/ Interests: _____

Social Resources/Needs: _____

Family members with whom participant has supportive relationship:

Neighbors/ Friends who are supportive:

Social / Conversational skills:

Initiates/engages in conversation: YES NO
Comments: _____

Maintains social contacts: Neighbors Church Friends Other _____
Comments: _____

Seeks needed help or assistance: YES NO
Assistance requested: _____ From: _____
Comments: _____



Has someone to confide? YES NO Name: _____
 Comments: _____

Has someone who will provide necessary help in event of sickness YES NO
 Person Name: _____
 Comments: _____

Has meaningful role with Neighbors Church Friends Community Social Group Other
 Comments: _____

Social support system appears:
 ___ Very Supportive
 ___ Adequate
 ___ Inadequate
 ___ No social support system

Interviewer's comments:

Social needs: _____

Physical Resources/ Needs

Ambulation: Independent Dependent
 Walks with assistance of: ___ Cane ___ Tripod
 ___ Walker ___ Wheelchair ___ Support of another person
 Needs help with: ___ Stairs ___ Carpeted floors ___ Uneven terrain
 Any paralysis: _____ What part of body: _____

Difficulty with motor control: YES NO
 Comments: _____


LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.
(Functional Assessment)

Any sensory loss: YES NO

Describe: _____

Speech impediment/aphasia: YES NO

Describe: _____

Loss of bowel/Bladder YES NO

Describe: _____

Condition of teeth and gums: Natural Missing: Top ___ Bottom ___ Dentures Partials: Upper or Lower

Comment: _____

Weight Changes (within past 15-30 days) Loss _____ (lbs.) Gain _____ (lbs.)

Comment: _____

Evidence of malnutrition: YES NO

Describe _____

Therapeutic diet: YES NO

Describe _____

Acute health problems: YES NO

Describe _____



Chronic health problems: YES NO

Describe _____

Prescribed medications: For:
ATTACH COPY OF MEDICATION SHEET

Non-prescription drugs: For:
ATTACH COPY OF MEDICATION SHEET

Can take own medication: YES NO
 Needs supervision: YES NO
 Medication Administration YES NO
 Any history of alcoholism: YES NO How much per day: _____ Last use: _____
 Any use of tobacco products YES NO Type/Frequency: _____ Last use: _____
 Other substance addiction: YES NO Describe: _____ Last use: _____

Days of illness during last six months (unable to carry out normal activities):
 Describe _____

In past 6 months, number of days spent in Hospital _____ Nursing home _____ Rehab _____ Psych Unit _____
 Describe _____

Able to participate in physical activities: Walking Swimming Exercise Outdoor games
 Describe _____

Any prescribed therapy or activity: _____

Any supportive devices being used:
 ____ Leg brace ____ Artificial limb ____ Hearing aid
 ____ Glasses ____ Contact lenses ____ Dentures
 ____ Catheter ____ Kidney/dialysis ____ Colostomy equipment

Other/Comment: _____



**LIFE'S ESSENCE
ADULT DAY SERVICES**

Non-Profit, Inc.
(Functional Assessment)

Any special instructions/ assistance needed with these: _____

Describe _____

Interviewer's comments: _____

Needs not presently being met: YES NO
Describe _____

Mental/ Emotional Resources and Needs YES NO
Describe _____

Diagnosed mental/emotional illness/problem: YES NO
Describe _____

Any observed indications/symptoms of mental/emotional disorders:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> Hypochondria | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Sense of uselessness |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Acting out | <input type="checkbox"/> Aggressive behavior |
| <input type="checkbox"/> Sexual fixation | <input type="checkbox"/> Hostility | <input type="checkbox"/> Self-neglect/ abuse |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Wandering | <input type="checkbox"/> Other |

Describe Six: _____

Able to verbally express self: YES NO
Exhibits understanding of others: YES NO
Appears able to make decisions: YES NO

If no to any above, please explain: _____



Exhibits evidence of: Independence Dependence
 Example(s): _____

Evidence of self-motivation: YES NO
 Appears to maintain healthy relationships: YES NO
 Copes well with others: YES NO
 Manages personal affairs: YES NO
 Another person manages affairs: YES NO
 Shows common sense in making judgements: YES NO

Exhibits ability to adapt to new circumstances and situations: YES NO
 Demonstrates ability to adjust to any loss of function/change in roles: YES NO

Finds use for leisure time: YES NO
 List activities: _____

Interviewer's comments: _____

Needs not presently being met: YES NO
 Example(s): _____

ADL Resources and Needs

Cares for personal grooming:
 ___ Well
 ___ Adequately
 ___ Inadequately
 ___ Has help (Describe: _____)
 ___ Grooming not cared for (Describe: _____)



Is applicant able to care for personal needs?

- 1= Without assistance
- 3= Assistance of equipment
- 5=Assistance of equipment & person

Insert code below:

- 2=Supervision is needed
- 4= Assistance of a person
- 6= Unable to accomplish
- 7= not observed

- A. Eating _____
- B. Meal preparation _____
- C. Toileting _____
- D. Dressing/Undressing _____
- E. Bathing _____
- F. Getting in and out of bed _____
- G. Household chores _____
- H. Shopping _____
- I. Laundry _____
- J. Manages finances _____
- K. Manages household _____
- L. Takes own medications _____
- M. Uses public transportation _____
- N. Uses telephone _____

Data provided by: _____

Relationship: _____

Date: _____

Interviewed by: _____

Title: _____

Date: _____

Interviewer's Signature: _____

Date: _____



EMERGENCY CONTACT INFORMATION

Date: _____

Participant Name: _____ Preferred Name _____

Last First MI

Address: _____
 Street City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Current Age: _____ State of Birth: _____

Social Security #: _____ Sex/Gender _____ Race/Ethnicity: _____

Marital Status: S M W D Spouse/Significant Other: _____

Religious Preference: _____ Place of Worship: _____

Former Occupation: _____ Military Branch: _____

PHYSICIAN INFORMATION

Physician: _____ **Primary Care Doctor** Last Appointment _____

Name: _____

Address: _____

Office #: _____ Fax: _____

NEAREST RESPONSIBLE RELATIVE/FRIEND:

_____ Full Name	_____ Relationship	_____ Length Known	_____ Power of Attorney
_____ Email	_____ Work #	_____ Cell #	_____ Alternate #
_____ Street	_____ City	_____ State	_____ Zip

EMERGENCY CONTACTS:

Two Persons who can be contacted in addition to above:

_____ Full Name	_____ Relationship	_____ Length Known	_____ Power of Attorney
_____ Email	_____ Work #	_____ Cell #	_____ Alternate #
_____ Street	_____ City	_____ State	_____ Zip

_____ Full Name	_____ Relationship	_____ Length Known	_____ Power of Attorney
_____ Email	_____ Work #	_____ Cell #	_____ Alternate #
_____ Street	_____ City	_____ State	_____ Zip



Medical Emergency Authorization Form

I, _____ (person legally responsible/Participant/Family/Caretaker), hereby authorize Life's Essence Adult Day Services' Director or designee to obtain necessary health care services and transportation for _____ (participant's name) in the event of a medical emergency while I am a participant in the program. The cost of these medical services are the responsibilities of the participant.

Signature of Participant

Print Name

Date

Signature of Family Member or Representative

Print Name

Date



PARTICIPANT OR GUARDIAN'S CONSENT TO SPEAK TO THE MEDIA

RE: _____
(Print full name of PARTICIPANT) (Date of Birth)

I (We), _____ (Print Name of Adult(s) or Guardian), hereby grant permission to Life's Essence Adult Day Services, Inc. for the above named to provide information to/be interviewed by the media, for the _____ (Indicate specific event).

This includes the use of interviews, photographs, audiovisuals, or public/promotional appearances.

I (We) have had the Center's confidentiality policy explained to me (us). I (We) have been informed of and understand that I may provide confidential information about myself to the media.

I (We) understand that names of individuals, children or families shall not be used without express permission of the participant or their guardian.

I (We) release and discharge Center, its agents and employees, from all liability, claims or demands in law or in equity arising from the use of such interviews, photographs, audio/visual materials, and from the use of public/promotional materials. I (We) _____ further discharge the Center from liability in the event that I (we), voluntarily or inadvertently disclose confidential information about myself (ourselves) or others.

This consent or authorization shall be effective the date of signature and shall expire twelve months from the date of signature which is (enter date): _____.

I (We) understand that I (we) may revoke this consent or authorization at any time, providing I (we) notify the Center in writing to this effect. Revocation has no effect on action previously taken.

I (We) authorize that a photocopy of this informed consent may be considered as valid as the original.

(Signature of Participant or Guardian) (Date)

(Address of Participant or Guardian) (Telephone)

(Signature of Witness) (Date)

PARTICIPANT OR GUARDIAN'S CONSENT TO SPEAK TO THE MEDIA If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer:

_____.



Non-Profit, Inc.

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(CONSENT TO SPEAK TO THE MEDIA)

CONSENT OR AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, hereby authorize:
(Print name of participant)

Name of Organization: _____

Address of Organization: _____

to release confidential information consisting of (Indicate the specific information that may be released, i.e., Psychiatric, Drug / Alcohol Records or Information, HIV or AIDS Information, History & Physicals, Immunizations, Medical Records or Information; Social History; Psychological Records or Information, Educational or School Records, etc.)

Regarding (Participant): _____ Date of Birth: _____

This information is requested, order to provide individualized service for his/her daily care at our facility:

Name of Organization: **Life's Essence Adult Day Services, Inc. - LEADS**

Address: 1068 Arlington Road N.
Jacksonville, Florida 32211

Phone: 904-503-2244

Fax: 904-503-2284

Attention: Bercline Dorcelus, BSN, RN
Center Director

I understand that only the above-specified information can be disclosed by the above-specified organization. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]



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CONSENT TO SPEAK TO THE MEDIA

If the guardian is the person authorizing the disclosure of the specified information, please complete information below.

Name: _____ Phone: _____ Email: _____

Address: _____

The guardian's signature below indicates that he or she certifies that they have the legal authority to consent for the disclosure of the specified information.

This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature which is (enter date): _____ or at the time services are concluded if before one year.

I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken.

(Signature of participant or guardian if participant is unable to sign)

(Date)

(Signature of witness)

(Date)

If the participant or guardian has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the participant or guardian:

_____.



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CONSENT TO SPEAK TO THE MEDIA

PRE-ADMISSION PHYSICIAN'S ASSESSMENT

Today's Date: _____

Exam Date: _____ Date of Birth: _____ Sex: _____

Participant Name: _____
Last First MI

Street City State Zip

Primary Phone: _____ Alternate #: _____ Email: _____

Section 1: Medical History

Vital Signs: Blood Pressure _____ Heart Rate _____ Resp. _____ Temp _____ Wt. _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Chronic Illness: _____

Allergies: _____

Special Diet: _____

Recent Surgery (Type of procedure and date): _____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Recent Acute Illness (Type and date): Shingles or Chicken Pox Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Describe Current Treatment Plan (e.g., nursing, therapies, etc.):

Is Palliative Care appropriate/recommended? Yes No

If yes, describe services:

Activity Restrictions:

Physical/Cognitive Limitations:

Weight Bearing: Full Partial None

Cognitive Impairment/Memory Loss (including dementia):

Does the individual have/show signs of dementia or other cognitive impairment? Yes No

If yes, describe:

If yes, do you recommend testing be performed? Yes No

If yes describe

If testing has already been performed, date/place of testing if known: _____



Mental Health Assessment (non-dementia):

Does the individual have a history, current condition or recent hospitalization for mental disability? Yes No

If yes, describe:

Based on your examination, would you recommend the patient seek a mental health evaluation? Yes No

If yes, provide referral?

Is the individual's condition stable?

Yes No

If no, describe

Requires periodic intermittent nursing care, and/or medical examinations, doctor's visits, or skilled observation of symptoms:

Section II: Authorization for the Administration of Medication

Medications must be in the original container and labeled with participant's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Participant _____ Date of Birth ____/____/____ Date ____/____/____
 Allergies: _____

Pharmacy _____ Pharmacy Phone: _____

Medication Administration: Independent ____ Dependent ____ Supervised ____

List all current medications (prescription and OTC, including dosage, type, frequency, method of administration and note special instructions: (attach additional sheets if necessary signed and dated by Physician).

Medication	Dose	Route	Frequency	Reason/Diagnosis	Start Date	Stop Date
Ex: Tylenol	650 mg	PO	Q4H PRN	Pain or Fever	01/01/2017	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

I, _____ (participant/authorized family/caretaker) request that medication be administered to _____ (participant) as described and directed above. I attest that I have administered at least one dose of the medication to _____ (participant) without adverse effects.

I, _____ (participant/authorized family/caretaker) request that medication be self-administered to participant as described and directed above.



Non-Profit, Inc.
Page 4 of 7
(Physician's Assessment)

Name of Adult Day Care Program _____

Today's Date: _____

Participant Name: _____

Address _____

Name & relationship of person Authorizing Medication Administration: _____

Relationship: _____

Address _____

Phone: _____

Alternative # _____

Signature participant/authorized family/caretaker Authorizing Administration of Medication _____

Name of Personnel Receiving Written Authorization and Medication _____

Title/Position: _____

Signature of Personnel Receiving Authorization and Medication _____

HEALTH CARE PROVIDER

It is my professional opinion, based on my knowledge of his/her health status and physical condition, that _____
he/she is:

_____ Fully capable of self-administering his/her medications; or

_____ Requires supervision while self-administering his/her medications by a validated medication

_____ Administration assistant; or

_____ Requires medication administration by a validated medication administration assistant

Health Care Provider's Name

Health Care Provider's Signature

Date of Authorization



**LIFE'S ESSENCE
ADULT DAY SERVICES**

Non-Profit, Inc.

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(Physician's Assessment)

Section III: Observations of the Individual

(circle Yes or No)

Capable of self-administration of medication?	Yes	No
Ambulatory - without assistance	Yes	No
Ambulatory - with assistance	Yes	No
Chair fast – unable to transfer	Yes	No
Chair fast – able to transfer	Yes	No
Bedfast – unable to transfer	Yes	No
Bedfast – able to transfer	Yes	No
Continent of Bladder	Yes	No
Continent of Bowels	Yes	No
Dependent on alcohol	Yes	No
If yes, is the individual a danger to his/herself or others?	Yes	No
Cigarette, cigars, or any other tobacco use?	Yes	No
Uses recreational drugs?	Yes	No

Does the individual require supervision and/or assistance by aide with?

Bathing:	Yes	No	If yes, is it?	intermittent	constant
Grooming:	Yes	No	If yes, is it?	intermittent	constant
Dressing:	Yes	No	If yes, is it?	intermittent	constant
Eating:	Yes	No	If yes, is it?	intermittent	constant
Transferring:	Yes	No	If yes, is it?	intermittent	constant
Ambulation:	Yes	No	If yes, is it?	intermittent	constant
Toileting:	Yes	No	If yes, is it?	intermittent	constant

*Such that it requires toileting program 24 hours/7 days per week to maintain continence? Yes No

Evaluation In your opinion, do you feel this individual could benefit from adult day care? Yes No

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared for in an Adult Care Center.

MD, ARNP or PA Signature

Date

MD, ARNP or PA (Print)

Date

Address

Phone:

Section IV: Immunization

Today's Date: _____

Participant Name: _____ Gender: _____ Race/Ethnicity: _____

Address: _____

Street _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email: _____

Social Security #: _____ Date of Birth: _____ Current Age: _____

VACCINES

ADMINISTERED DATE

ADMINISTERED BY

- Hepatitis A (Havrix; Vaqta) Dose: 0.5 mL 1.0 mL _____
- HepA-HepB (Twinrix) _____
- Hepatitis B (Engerix-B; Recombivax HB)
 - Dose: 0.5ml or 1.0ml 1st Dose _____
 - Route: IM or ID 2nd Dose _____
 - 3rd Dose _____
- Human papillomavirus (HPV) _____
- HPV2 (Cervarix) _____
- HPV4 (Gardasil) _____
- HPV9 (Gardasil 9) _____
- Influenza
 - Brand _____
 - Dose (mL) _____
 - Route IM or ID _____
- IPV (Polio) _____
- Meningococcal
 - MenACWY (MCV4) (Menactra, Menveo [conjugate]) _____
 - MPSV4 (Menomune [polysaccharide]) _____
 - MenB (Bexsero, Trumenba [protein]) _____
- MMR Varicella (chickenpox) (Varivax) _____
- MMRV (ProQuad) _____
- NAS Zoster (shingles) (Zostavax) _____
- Pneumococcal
 - PCV13 (Pevnar 13 [conjugate]) _____
 - PPSV23 (Pneumovax 23 [polysaccharide]) _____
- Rotavirus
 - RV1 (Rotarix) _____
 - RV5 (RotaTeq) _____
- Tetanus _____
- Other: _____

 Doctor, ARNP, or Physician Assistant Signature

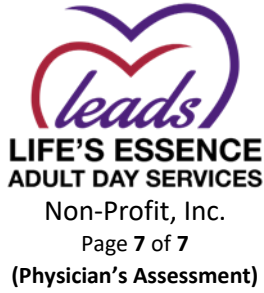
 Street City State Zip

 Email

 Phone #

 Date

 Fax #



Section V: Free of communicable disease

DATE: _____

To Life's Essence Adult Day Services, Inc. – LEADS

Mr. or Mrs. _____ (Patient), born _____ has been evaluated by _____ (MD, DO, PA, ARNP) at _____, (Name of health department/facility).

TUBERCULIN SKIN TEST/PPD/TB TINE

Date administered _____
 Administered by (Sign/Title) _____

Administration Site _____
 (Print) _____

Date Read: _____
 Results: Negative Positive
 Read by (Sign/Title) _____

Measurements _____ mm
 (Print) _____

CHEST X-RAY (CXR)

Date of CXR: _____
 CXR Report: _____ No active disease

_____ No evidence of active tuberculosis

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

CXR Report: _____ Abnormal Report

_____ Abnormal, active tuberculosis to be ruled out

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

 MD, ARNP, or PA

 Date

 Address

 Phone:

DNRO Code form

(must print/sign on yellow paper)



History & Physical

(within 6 months)
(Obtain copy from MD)