LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.
1068 Arlington Road N., Jacksonville, FL. 32211 * P: 904-503-2244 * F: 904-503-2284 * Leadsvcs@gmail.com * www.Leadsvcs.com

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:	**Date Received**	**Received By:**
• Schedule a visit	_____	_____
• Welcome Letter	_____	_____
• Admission Criteria	_____	_____
• Activity Schedule	_____	_____
• Operating Policies	_____	_____

PRE-ADMISSION	**Date Received**	**Received By:**
• 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	_____	_____

Forms to be completed by Primary Care Physician	**Date Received**	**Received By:**
• 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)	_____	_____

POST ADMISSION	**Date Received**	**Received By:**
• 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	_____	_____

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

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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 Bercline Dorcelus at Leadsvcs@gmail.com or call us at 904-503-2244.

We look forward to hearing from you soon!

Sincerely,

BDorcelus, BSN, RN, CDN

Bercline Dorcelus, BSN, RN, CDN

Director * Notary Public

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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.

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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

ACTIVITY SCHEDULE

TIMES	ACTIVITIES
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 ACTIVITES / 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

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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 tim es will be based on what we determine to be very hazardous driving conditions and concern for safety. Pr ogram 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.

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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

MEDICATIONS

FEES

PARTICIPANT SUPPLIES

SOCIAL MEDIA

EXTENDED ABSENCES

LATE PICK UPS

TERMINATION / DISCHARGE

DISASTER PREPAREDNESS

ASSISTIVE DEVICE

SMOKING

GRIEVANCES

GIFTS TO EMPLOYEE

CANCELLATION/TERMINATION REQUEST

SIGN IN/OUT SHEET

FINANCIAL ASSISTANCE

FOOD SERVICE

TRANSPORTATION

ATTENDANCE / ABSENCE

MAKE UP DAYS

WITHDRAWAL

EMERGENCIES

ADVANCED DIRECTIVES

VALUABLES / CLOTHING / PERSONAL BELONGINGS

VISITS

ABUSE AND NEGLECT

FIELD TRIPS & SPECIAL EVENTS

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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: _____
_____

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.
(Application for Service)

INSURANCE:

Insurance Name: _____ Policy # _____ Phone # _____

Private Pay Yes No Payment Schedule: Weekly Bi-Weekly Monthly

Medicare Yes No Policy # _____ Phone # _____
Medicaid Yes No Policy # _____ Phone # _____
Long-Term Care Ins. Yes No Policy # _____ Phone # _____
Supplemental Ins. Yes No Policy # _____ Phone # _____

Responsible Party: Participant Guardian Power of Attorney Other _____

Responsible Party Information
Name: _____ Email: _____
Address: _____
_____
Home Phone: _____ Cell: _____ Work: _____

CARETAKER OR GUARDIAN COMPLETING APPLICATION:

Name: _____ _____
Last First MI Relationship

Address: _____
Street City State Zip

Home/Work Phone: _____ Cell Phone: _____ Email: _____

EMERGENCY CONTACTS:

Name: _____ Relationship: _____ Cell # _____
Name: _____ Relationship: _____ Cell # _____
Name: _____ Relationship: _____ Cell # _____

HOSPITAL:
1ST Choice _____ 2nd Choice _____

Does applicant have an advance directive? Yes ____ No _____
Do you have legal guardianship or power of attorney? Yes ____ No _____
Has applicant's doctor recommended/prescribed adult day care services? Yes ____ No _____

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.
(Application for Service)

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: _____

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.
(Application for Service)

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% _____ (Severe) 50% _____ (Moderate) 75% _____ (Mild) 100% _____ (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 _____
_____
_____

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.
(Application for Service)

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:

_____	_____	_____
_____	_____	_____
_____	_____	_____

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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. _____

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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: _____

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

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

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: _____
_____

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

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 _____
_____
_____

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

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:

____ Depression	____ Anxiety	____ Withdrawal
____ Paranoia	____ Hypochondria	____ Confusion
____ Disorientation	____ Memory loss	____ Sense of uselessness
____ Hallucinations	____ Acting out	____ Aggressive behavior
____ Sexual fixation	____ Hostility	____ Self-neglect/ abuse
____ Anger	____ Wandering	____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: _____)

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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: _____

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

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

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.
(Emergency Contact)

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

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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:
_____.

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

(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]

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:
_____.

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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: _____
_____ 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: _____

_____

_____

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

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.

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

(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.

(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 program24 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:

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

(Physician's Assessment)

Section IV: Immunization

Today's Date: _____

Participant Name: _____ Gender: ____ Race/Ethnicity: _____
Last First MI

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)	1st Dose _____	_____
○ Dose: 0.5ml or 1.0ml	2nd Dose _____	_____
○ Route: IM or ID	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 (Prevnar 13 [conjugate])	_____	_____
○ PPSV23 (Pneumovax 23 [polysaccharide])	_____	_____
• Rotavirus		
○ RV1 (Rotarix)	_____	_____
○ RV5 (RotaTeq)	_____	_____
• Tetanus	_____	_____
• Other: _____	_____	_____

_____ _____ _____
Doctor, ARNP, or Physician Assistant Signature Email Date

_____ _____ _____
Street City State Zip Phone # Fax #

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

(Physician's Assessment)

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 _____ Administration Site _____
Administered by (Sign/Title) _____ (Print) _____

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

LIFE'S ESSENCE
ADULT DAY SERVICES
Non-Profit, Inc.

History & Physical

(within 6 months)
(Obtain copy from MD)