Section I Application

Name: ________________________________ Date of Birth: ___________________
Primary caregiver name: ________________________________
Responsible Party name: ________________________________
Power of Attorney* name: _______________________________

Veteran? Yes [ ] No [ ]
If Yes:
Dates served: ___________________________________
Branch of Service: _______________________________
Social Security: _________________________________

Medicaid Eligible? Yes [ ] No [ ]
If Yes,
Medicaid #: ____________________________
Application in progress? Yes [ ] No [ ]
Social Worker Name: _____________________________
County: ________________________________

Long Term Care Insurance? Yes [ ] No [ ]
If Yes,
Company: _______________________________
Policy #: ________________________________
Address: ____

New River Valley Respite Care Grant eligible? Yes [ ] No [ ] Unsure [ ]

Do you have an Advance Directive?* Yes [ ] No [ ]

Do you have an order of Do Not Resuscitate?* Yes [ ] No [ ]

*(Virginia Department of Social Services requires that we have in the chart copies of any Power of Attorney, Advance Directive and/or original order of Do Not Resuscitate.)

Signature of Preparer _______________________________ Date:_______________

Print Name of Preparer _____________________________________

Section II Contact Information

Participant Address Street 1: ______________________________________

P.O. Box_______ Street 2:____

Apt. # __________City: _______________________ State: _____________

Zip code: _____________ Home phone: ____________________

Primary caregiver: __________________________________

Relationship to participant: ___________________________

Is the address the same as above: Yes [ ] No [ ]

If different from above: Street 1: ___________________________________

P.O. Box: _______ Street 2: _______________________________________

City: ___________________________ State: ________________

Zip code: _____________ Home phone: ____________________

Primary caregiver/contact telephone numbers: Home _________________
Work _________________ Cell _________________

Living: [ ] Alone & Independent
[ ] Alone with Assistance from __________________________

Living with Spouse [ ] Adult Child Friend [ ] Other relative [ ]

Emergency Contacts: Primary Contact as above? Is so, please check here [ ]
If **NOT**, please check here [ ] and name: ___________________________
Please list in the order of preferred contact.

Caregiver/contact 1: ___________________________

Relationship to participant: ___________________________

Address, if same as participant's, check here: [ ]

If different or not listed above: Street 1: ___________________________________

Street 2: ___________________________________ City: ____________________

State: _________________ Zip code: _____________

Home ________________ Work ________________ Cell _________________

P.O. Box: ________________

Caregiver/contact 2: ___________________________

Relationship to participant: ___________________________

Address, if same as participant's, check here: [ ]

If different or not listed above: Street 1: ___________________________________

Street 2: _____________________________________ City: __________________

State: ______________ Zip code: ______________

Home _________________ Work ________________ Cell _________________

P.O. Box: ______________

Caregiver/contact 3: ___________________________

Relationship to participant: ___________________________

Address, if same as participant's, check here: [ ]

If different or not listed above: Street 1: ___________________________________

Street 2: _________________________________ City: _____________________

State: ______________ Zip code: ______________

Home ________________ Work ________________ Cell _______________

Please notify us immediately of any changes in this information.

Phone: 540-231-3161 Email: schepisi@vt.edu
Date: _________ Staff Initials:_____

Medical Contact Information
Primary Care Physician Name: ______________________________

Address: ____

Telephone: ___________________________

Conditions Treated:

____

____

Dentist Name: ____

Address: ____

Telephone: ___________________________

Conditions Treated:

____

____

Hospitalizations in past year:

Name: ________________________ City: _____________________

Conditions Treated:

____

____

Name: ________________________ City: _____________________

Conditions Treated:

____

____

Other physicians seen in the past year and conditions treated:

Name: ____________________________

City: ____________________________

Conditions Treated:

____

____

Name: ____________________________

City: ____________________________

Conditions Treated:

____

____

Name: ____________________________

City: ____________________________

Conditions Treated:

____

____

Phone: 540-231-3161 Email: schepisi@vt.edu
Date: _________ Staff Initials:_____

Section III

ENROLLMENT AGREEMENT & PERMISSION (Please complete and sign both Parts A and B)

A. ENROLLMENT AGREEMENT

I have received a copy of the Adult Day Services Family Handbook. I understand the conditions for dismissal or discharge as outlined in the Family Handbook. I also understand the conditions for financial arrangements as outlined in the Family Handbook.

____________(Participant Name) will attend the following days:

M [ ] T [ ] W [ ] Th [ ] F [ ]

Approximate hours of attendance per day: ____________

Adult day services provides preventive and/or protective services for adults who are not capable of full independent living. Physically and/or mentally frail older adults are able to continue living in the community, while respite is provided for the caregivers. Most importantly, activities and opportunities are provided to maintain or improve levels of physical, cognitive, social and emotional functioning.

Virginia Tech Adult Day Services staff agrees to provide the following services according to an individualized plan of care:

- Lunch (provided to ADS by the New River Valley Area Agency on Aging Meals on Wheels program) and two snacks per day
- health monitoring and medication supervision
- therapeutic recreation programs such as reminiscence, active games, community involvement projects, discussion groups, cards, word and board games
- daily physical exercise
- life enrichment programs such as art, music and horticultural sessions
- leisure activities including hobbies, crafts and local outings
- intergenerational activities

Monthly bills for services should be sent to:

Name: ______________________________

Address: ____

Signature: ________________________________ Date: ______________

* Please complete this document in the presence of Adult Day Services staff.

B. PERMISSION TO PROVIDE SERVICES
Consistent with the missions of the University, Virginia Tech Adult Day Services provides a community service to frail and or impaired adults, learning experiences for students, and opportunities for students and faculty to participate in a variety of research projects. In order to be sure participants and their responsible persons are aware of and understand the various elements of these activities, we are asking you to give permission for the following. Please check the blanks and sign below.

[ ] a. *Permission to photograph*. I understand that video, sound tape recordings, movies and photographs may be made of Adult Day Services groups. These may be used for educational purposes and professional presentations. I understand that I will be informed as to specific publications and can then decide if I wish to give permission for image and/or sound reproduction to be published.

[ ] b. *Investigations and Research Projects*. I understand that students under the supervision of instructors may occasionally question or provide special activities for participants, which are part of the students' learning experiences. Furthermore, Adult Day Services clients may be participants in student or faculty research projects, the results of which may be disseminated to audiences beyond the classroom. In this case, I understand that I will be informed as to the specific study and can then decide if I want (my adult relative) to participate.

[ ] c. *Release of Information*. I authorize the release of personal information as may be necessary for completion of forms and/or claims which are related to participation in the adult day services program to include NRV Area on Aging.

[ ] d. *Emergency Medical Care*. If the staff determine that medical care is needed, every possible effort will be made to first contact the adult's responsible party (emergency contacts) so that he/she can help in planning further steps to be taken. If emergency medical attention is needed and the responsible party cannot be reached or if there is no time to reach the person first, staff may call 9-1-1 to obtain immediate medical aid. The client's physician named below and Montgomery County Hospital Emergency Room are default treatment sources. I authorize the personnel in the Virginia Tech Adult Day Services to secure emergency medical aid for me (my adult relative).

Participant Name: __________________________

Responsible Party: __________________________ Daytime phone #: _____________
(Responsible Party or Agency Name)

Participant's Physician: __________________________ Phone #: ______________

Signature: ___________________________________ Date: ______________
(Caregiver or Participant)

Section IV Participant Social History

Military Service – None [ ]
Branch of Service ____________Years _____ through _____
Describe type of duty and whether active combat.

____

Education
Highest grade/Degree completed ___________ Where? _____________
Area of study, if applicable: ____________________________

Religion/Spiritual Life
Grew up in Denomination / Current Status
____________ / ____________
As Adult Denomination / Current Status
____________ / ____________

Other information, important to religious or spiritual beliefs?

____

Family of Origin
Father's name: _________________________
Education: _______________ Occupation: ______________________
Health issues, if any:

____

____

Mother's name: _________________________
Education: __________ Occupation: _________________________
Health issues, if any:

____

Siblings
Name / Gender / Where Live? / Health Issues (&/or Cause of Death & Age)
_______ / __ / _________ / _________ (&/or _________ & _________)
_______ / __ / _________ / _________ (&/or _________ & _________)
_______ / __ / _________ / _________ (&/or _________ & _________)
_______ / __ / _________ / _________ (&/or _________ & _________)
_______ / __ / _________ / _________ (&/or _________ & _________)
_______ / __ / _________ / _________ (&/or _________ & _________)

Family as Adult

Marriage/Long Term Relationship

If never married, check here: [ ]

To whom /When / How long

_______________________ / ___________ / ___________

Current Status:

Still Married [ ] Widowed [ ] Divorce [ ] Separated [ ]

Part of care plan? Yes [ ] No [ ]

Children

Name / Birth Year / Gender

_________________________ / ______________ / ______________

Where live? _____________________ Part of care plan? Yes [ ] No [ ]

Name / Birth Year / Gender

_________________________ / ______________ / ______________

Where live? _____________________ Part of care plan? Yes [ ] No [ ]

Name / Birth Year / Gender

_________________________ / ______________ / ______________

Where live? _____________________ Part of care plan? Yes [ ] No [ ]

Name / Birth Year / Gender

_________________________ / ______________ / ______________

Where live? _____________________ Part of care plan? Yes [ ] No [ ]

Grand- or Great-grandchildren?

____

____

____

____

Friends
Current friend's name? ____________________________
Common Interests? ____________________________
Contact frequency? _________ Type of contact?
Face-to-face? [ ] Home? [ ] Out in community? [ ] Telephone? [ ]

Current friend's name? ____________________________
Common Interests? ____________________________
Contact frequency? _________ Type of contact?
Face-to-face? [ ] Home?[ ] Out in community? [ ] Telephone? [ ]

Current friend's name? ____________________________
Common Interests? ____________________________
Contact frequency? _________ Type of contact?
Face-to-face? [ ] Home?[ ] Out in community? [ ] Telephone? [ ]

Past important friends? / Common interests?
____________________________ / ____________________________
____________________________ / ____________________________
____________________________ / ____________________________
____________________________ / ____________________________

Where did the participant live growing up and as an adult?
____
____

Did the participant travel much to different places? Where?
____
____

What was the primary language he/she spoke as a child?
____

What is the primary language he/she speaks now?
____

Work/Occupation Years

Longest occupation / Years of duration

______________________________ / ______________________________

Other meaningful occupations? / Years of duration

______________________________ / ______________________________
______________________________ / ______________________________
______________________________ / ______________________________

Hobbies and Special Interests in the past and/or now?

Type of activity / Years enjoyed

______________________________ / ______________________________
______________________________ / ______________________________
______________________________ / ______________________________

Other information that is important to you and may help us know you better:

____
____
____
____
____

Section V Family Care giving History

Please describe you and your family's background in caring for other relatives and friends in the past. Are there any other persons you are caring for now?

____

____

Please describe the recent past and current tasks of care giving in which family and friends have engaged. Include any professional sitter or aide arrangements.

____

____

How will these arrangements change once Adult Day Services is in the mix?

____

____

Have you experienced negative results or interactions with health professionals or agencies that we can help you avoid?

____

____

How can we help get you information you need to make arrangements more easily?

____

____

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Date: __________ Staff Initials:_____

Section VI Support Available
(These arrangements may change over time.)
How will you pay for Adult Day Services and/or other home or residential care? Please check **all** that might apply.

[ ] Medicaid
[ ] Veterans Affairs
[ ] Long Term Care Insurance
[ ] Savings or other assets
[ ] Other community funding (e.g., NRV Respite Grant)
[ ] Other family resources

Other: ____________________________

How will you transport and otherwise help get the participant to and from Adult Day Services? (Check all that might apply)

[ ]Immediate family
[ ]Extended family and friends network
[ ]Paid Home helper/aide
[ ]Blacksburg Transit Access program (available within town limits)
[ ]New River Senior Services program
[ ]Radford Community Transit program
[ ]Medicaid transportation provider

Other: ____________________________

How will you manage overnight stays away from home and your participant?

[ ]Always take with
[ ]Extended family and friends network come into participant's home
[ ]Others invite participant into their home(s)
[ ]Respite overnight care through an agency/facility

Other: ____________________________

Section VII Physician's Assessment: Medical History & Reports
(*Physical examination required with in 30 days of admission. This section must be completed by the physician) **-** Attach additional pages, if necessary

Participant's Name: ______________________________________
First Middle Last

Medical Information & History

Diagnoses and/or Significant Medical Problems:

____

____

____

____

____

Is this person currently receiving therapies, treatments, or procedures?
______Yes ______No if Yes, please list:

Treatment Frequency Treating Physician or Therapist

____

____

____

____

Relevant Past Major Illnesses

____

____

Past surgeries, therapies or rehabilitations

____

____

Hospitalizations (with dates)

____

____

Health Care or Services Agencies Used in Past Year:

Agency Name: ____________________________

Services: ________________________________

Telephone: ______________________________

Address: ____

Agency Name: ____________________________

Services: ________________________________

Telephone: ______________________________

Address: ____

Is this person physically and mentally able to make an exit from the building in an emergency without assistance?

______Yes ______No If no please explain:

____

____

Limitations:

Adult Day Services incorporates daily planned exercise into its activity programming. "Planned exercise" is structured to maintain or improve physical and mental functioning. The exercise programs could consist of stretching, strength training, and cardiovascular activities. Each exercise is tailored appropriately for individual abilities.

Are there any former or current injury/conditions, which affect this patient's ability to participate in such an exercise program?

____

____

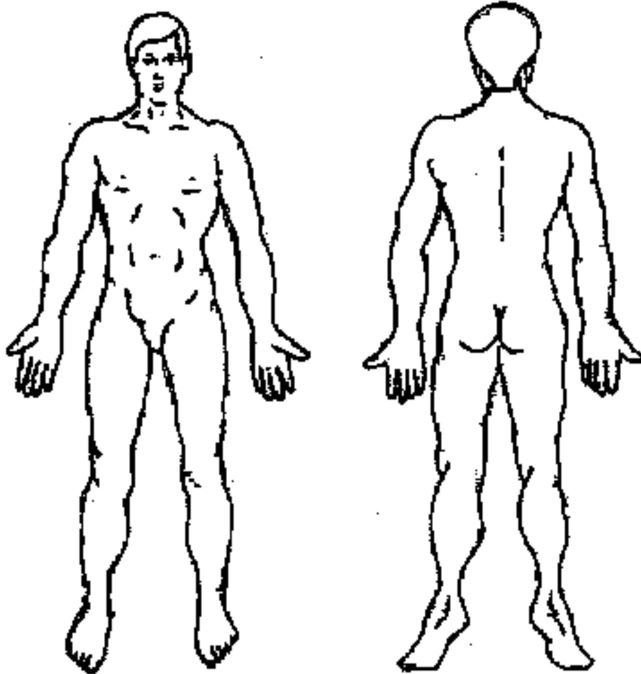
____

____

____

____

Please indicate on the diagram below, the part(s) of the body (and the restrictive conditions), which should be considered when planning an appropriate exercise program.



Vision restricted by ____

Hearing restricted by ____

Hearing Aid used ____

Feeding self restricted by ____

Chewing restricted by ____

Walking restricted by ____

Walking aid used (cane, walker, etc) ______________________________

Self-toileting restricted by ___________________________________

Dressing self restricted by ___________________________________

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Date: _________ Staff Initials:_____

Dietary Restrictions
Special Foods or Supplements from home:

____

____

Allergies to food or drink products:

____

____

Seasonal / Environmental or other allergies:

____

____

Disliked food or drink:

____

____

Favorite food or drink:

____

____

Is this person capable of administering his/her own medications?
______Yes ______No

Current Medications (including prescription, herbal, vitamins):

Medication Name	Start Date	Route	Dose	Frequency (include prn)	Form

Date: _________ Staff Initials:_____

PERMISSION TO ADMINISTER MEDICATIONS

ACCORDING TO VIRGINIA STATE LICENSURE STANDARDS, ADULT DAY CARE STAFF MAY ADMINISTER PRESCRIBED MEDICATIONS IN THE PLACE OF FAMILY MEMBERS WITH THE PERMISSION OF THE ATTENDING PHYSICIAN.

PERMISSION TO ADMINISTER PRESCRIBED MEDICATIONS IS GRANTED TO THE VIRGINIA TECH ADULT DAY SERVICES WHILE THIS INDIVIDUAL IS ATTENDING ADULT DAY SERVICES.

Physician Comments:

____

____

____

____

____

PHYSICIAN SIGNATURE__________________________ DATE _______

Physician Name (printed):

____

Address:

____

____

Phone:

____

Date of most recent Physical: __________

Section VIII Family & Participant Expectations of Adult Day Services

What does your family hope Adult Day Services will provide to the participant and to family members close to the situation? (e.g., social interaction with peers)

____

____

____

What would you like to see happen as a result of using the services here? (e.g., caregiver able to do errands and see friends)

____

____

____

What circumstance do you expect might make Adult Day Services less of a solution to your situation? (e.g., transportation problems)

____

____

____

Thank you for your patience in completing this form. Other information is available on our website and we encourage you to explore the opportunities to learn more about what Virginia Tech Adult Day Services does and can do for you.

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