Admission Process

***Please note any medications brought to the center for the nurse MUST be in its original bottle. Please do not have clients bring in any large purses or backpacks to the center.**

Insurances which cover 100% of Adult Day Health Services and transportation

- Masshealth Standard
- Masshealth Commonhealth
- One Care; CCA
- Fallon Navicare Senior Care options
- Tufts – Senior Care Options
- United Health Care Senior Care options
- Senior Whole Health
- Contracts with Baypath Elder Services/Springwell Elder Services/Tri Valley Elder Services

Private Pay per day (includes breakfast, snack, lunch and field trips)

Basic Level of Care: $73.25
Complex Level of Care: $89.25

Transportation – One way, $9.25 for first 3 miles, then $.75 for every mile after that.
Example – If client lives in Natick, 12 miles away from Liberty ADH, it would be $9.25 (first 3 miles) plus $6.75 for additional 9 miles. Total: $16.00 one way.

Instructions

1. Fill out all requested information
2. Once complete, mail, fax, scan or email application to the center
3. After receiving the application, the center will call and set up an appointment for a visit and for the applicant to be evaluated

Questions or Concerns

Please call Liberty Adult Day Health, 508-497-2300
Admissions/Service Coordinator x108
Registered Nurse x 104
Program Director x 105
City Voyager transportation: 508-494-9769

Admission Screening for Adult Day Health

Applicants Name: _____Nickname: _____
Address: _____
Phone: _____ Date of Birth: _____ Age: _____
Sex: M F Religion: _____Primary Language: _____
Marital Status: Single Married Divorced Widowed
Do you have: Masshealth If yes, Card # _____
Name of other Insurance Company _____
Phone # _____ Social Security # _____
In Case of Emergency Notify:
Name: _____Relationship: _____
Address: _____
Home # _____ Cell # _____
Work # _____ Email _____
Children or other interested parties:
Name: _____ Relationship: _____
Address: _____
Home # _____Cell #
Work # _____ Email _____
Legal Status- **Provide legal documentation**

Advanced Directive: ***Please note Liberty ADH must have a copy of legal documentation from the Primary Care Physician in order to honor a DNR. We must have copy of any advanced directives on file.***

LEGAL STATUS	Name	Relationship	Number
Do **N**ot **R**esuscitate			
Health Care Proxy			
Legal Guardian			
Power ofAttorney			

Referral
How did you hear about Liberty ADH? _____
Reason for referral: ____Doctor Recommended _____Family Request _____Client Request

Reason for seeking Adult Day Health? (Check all that apply)

☐ Safety	☐ Therapy Services	☐ Intellectual Stimulation
☐ Socialization/Friendships	☐ Nursing Services	☐ Caregiver Respite
☐ Medication Management	☐ Supervision	☐ Therapeutic Recreation

Other: _____
Is the client enrolled in ADH, currently? **If so, where**? _____

Reason for leaving?

Which days are you interested in attending Liberty? Mon Tue Wed Thurs Fri Sat

Who does applicant live with?

Type of Dwelling: House ____ Apartment _____ other, specify _____ Stairs _____

Will you provide transportation? _____ ***Requesting transportation?*** _____ if yes,

Does the applicant carry a house key? _____ Can applicant be left home alone? _____

Does applicant need assistance getting in and out of the van? _____

Is it safe for applicant to attend community field tips with Liberty ADH? Yes or N

Identify current In-home services

☐ Nursing	☐ Physical Therapy	☐ Occupational Therapy	☐ Home Care Aid	☐ Home-maker

Additional Caregiver (agency or family)

Name _____#_____

Does caretaker feel the need for support? Explain

Medical Contacts:

Include Primary Care Physician and all Specialists

Name of Physician	Specialty	Town	Phone
	Primary Care Physician		

Pharmacy: _____ Town: _____ Number: _____

Preferred Hospital: _____ Number:_____

Medical Information and Health History

Diagnosis:_____

Medical Hospitalization Date _____Reason_____

Psychiatric Hospitalization Date _____Reason_____

Allergies to medications/reactions_____

Will medications need to be administered while at the day program? __ Yes __ No

If yes, please list those medications:_____

Please note that any medications to be given at the day program must be in the original prescription bottle and we will need a Dr's order sent to the Liberty RN

Current Medication	Dosage	Times Given/Frequency

I. Ever Experienced any of the following health problems:

☐ Diabetes	☐ Headaches	☐ Dementia	☐ Inability to speak
☐ Heart Attack	☐ Dizziness	☐ Alzheimer's disease	☐ Memory problems
☐ Kidney Problems	☐ High Blood Pressure	☐ Parkinson's disease	☐ Joint pain/arthritis
☐ Seizure	☐ Urinary Infection	☐ Multiple Sclerosis	☐ Fractures
☐ Stroke	☐ Skin Problems	☐ Chronic Lung Disease	☐ Thyroid Problems
☐ Heart Disease	☐ Head Injury	☐ Osteoporosis	☐ Hard of Hearing
☐ Heart Failure	☐ Stomach Problems	☐ Pneumonia	☐ Legally blind
☐ Pace Maker	☐ Cancer (specify)	☐ Diarrhea	☐ Alcoholism or drug use
☐ Anemia		☐ Constipation	
☐ Depression		☐ Incontinence	
☐ Anxiety			

If diabetic, how is it controlled? Please circle: Oral medication Injection Diet

If there are seizures, please explain _____

Environmental allergies? Yes or No Explain _____

Is supervision or help required with medication? Yes or No Explain, if yes_____

Can Liberty ADH administer the following if needed? _____Tylenol _____Cough Syrup

_____antacid _____ ibuprofen

Signature: _____

Nutrition

Diet	Appetite	Eating Challenges	Allergies
☐ **Regular** ☐ **Low Sodium** ☐ **Diabetic** ☐ **Other**	☐ **Good** ☐ **Fair** ☐ **Poor**	☐ **Chewing** ☐ **Swallowing** ☐ **Holding utensils**	

Any weight loss or gain over the last 6 months? _____

Troublesome foods: _____ Tea or Coffee with _____

II. Safety Concerns

☐ Flight Risk	☐ History of falls	☐ Inappropriate language
☐ Wanders	☐ Aggressive towards others	☐ Sexually acts out
☐ Puts Objects in mouth	☐ Aggressive towards self	☐ Destroys property
☐ Poor Balance		☐ Tantrums

Activities of Daily Living

0 = Independent – Completes task independently
1= Minimum Assistance – Occasional assistance or supervision may be needed
2= Moderate Assistance – Assistance or supervision is always needed
3= Maximum Assistance – Totally dependent on others

Activity	Ind 0	Min Assist 1	Mod Assist 2	Max Assist 3	Primary Source of help	Comments
Walking						
Standing						
Toileting						
Hygiene						
Eating						
Transportation						

Toilet Use	Medical Devices Used	Additional Information:
☐ Incontinent of urine/stool ☐ Needs reminders to go to the bathroom ☐ Uses depends	☐ Walker/Cane/Wheelchair ☐ Glasses ☐ Hearing Aid ☐ Dentures ☐ Oxygen	

III. Cognitive/Behavioral Status/Mental/Emotional

Applicants orientation ☐ Person ☐ Place ☐ Time	Short term memory ☐ Good ☐ Fair ☐ Poor	Long term memory ☐ Good ☐ Fair ☐ Poor
Speech ☐ Inability to word find ☐ Slurring ☐ Nonsensical speech	Communication ☐ Understands verbal direction ☐ Communicates needs ☐ Understands written instruction	Abilities ☐ Read ☐ Write

Diagnosis ☐ Depression ☐ Bipolar Disorder ☐ Anxiety ☐ Schizophrenia ☐ OCD/PTSD	Mood ☐ No issues ☐ Occasional sadness ☐ Feeling hopeless, lonely ☐ Manic behavior ☐ Suicidal thoughts	Behavior ☐ No issues ☐ Argumentative or irritable ☐ Withdrawn or unresponsive, ☐ obsessive behavior, aggression/lashing out
Anxiety ☐ Fearful of new situations ☐ Physical symptoms ☐ Constant worrier ☐ Hinders everyday function	Observations to share ☐ Withdrawn ☐ Socially isolated ☐ Agitated ☐ Relationship challenges ☐ Cooperative ☐ Dependent ☐ High stress /paranoid	Sleep ☐ Occasional issues ☐ Frequent oversleeping ☐ Frequent not sleeping ☐ Sleep interferes with normal functioning ☐ Takes medication to sleep

IV. Coping

Healthy coping methods ☐ Cuddling with a pet ☐ Walking ☐ Friends ☐ Crossword Puzzle ☐ Knitting	Unhealthy Coping methods ☐ Alcohol ☐ Cigarettes ☐ Drugs ☐ Marijuana

Family and Social History

Where did individual grow up? _____

Fathers Name: _____ Mothers Name _____

Names of living brothers and sisters: _____

Names of deceased brothers and sisters: _____

Relationship with siblings: _____Very Close____Good _____Fair ____Poor

Who is important in individual's life? _____

Is the individual a: _____Veteran _____Spouse of a veteran _____ Parent of a Veteran

What was the main occupation? _____

Morning person or night owl? _____ Like to nap? _____ When?_____

Activities of potential interest: _____

Describe strengths: _____Describe worries:_____

Billing
Name, address, and phone number of individual or agency responsible for payment of Adult Day Health Services
Name _____Phone _____
Address_____
Applicants Signature _____Date _____
Signature of Person Completing this form _____ Date _____

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Last Name: _____ First Name: _____ Middle Initial: _____
Mailing Address:_____

City:_____ State: _____ Zip: _____
Date of Birth: _____ Sex: Male ___ Female ___ Phone #: _____

Records Released Form:
Name (i.e. Health Facility, Provider): _____
Address: _____ Phone #: _____Fax #: _____
City:_____ State: _____ Zip: _____

Records Released To:
Liberty Adult Day Health
25 F South Street Hopkinton, MA 01748
Phone: (508) 497-2300 Fax: (508) 497-2320

Information to be Released/Obtained:
____ Medical Information Requested or PCP Documentation
____ Medical Information Requested or Physicians Summary Form
____ Hospitalization/Rehab (Medical) (Psychiatric) (Rehab)
____ Developmental Disabilities
____ Other:

Purpose or Need for Disclosure: *Admission to Adult Day Health Program and ongoing care*

This authorization is limited to the following time period: ___/___/___ - Date or Discharge from Liberty ADH

I have read and understand this authorization and had a chance to ask questions about the disclosure of the health information. I authorize release of my medical records in accordance with the specifications listed above. A photocopy of this consent shall be valid as the original. I am aware I can make changes to this Release/Obtain form at any time.

Signature of Patient or Authorized Person by Law:_____Date: _____