CIRCLE of FRIENDS
ADULT DAY SERVICES

Circle of Friends Adult Day Services

Enrollment Information

Date Completed: _____

Participants First Name	Participants Last Name	Date of Birth

		_____Responsible for Self _____Power of Attorney _____ Guardian
Language Spoken	Sex	Legal Status

M D W S		
Marital Status	Religious Preference	Insurance Name / Number

Home Address

Phone Number	Participant Resides With

Transportation Provider	Phone Number	Drop Off Time	Pick Up Time

Participants Contact Information		
Emergency Contact		
	Name	Relationship
	Address	
	Phone Number #1	Phone Number #2
Guardian Contact		
	Name	Relationship
	Address	
	Phone Number #1	Phone Number #2
Case Manager Agency Information		
	Name	Relationship
	Address	

	Phone Number #1	Phone Number #2

Enrollment Information

Diagnosis	
Allergies	

Primary Physician						
Name		Address				
Phone			City		Zip Code	

ADMISSION AGREEMENT

I understand that my acceptance into Circle of Friends Adult Day Services is provisional and that I will be evaluated for two weeks by the staff of the Center for appropriateness of this program for me.

Further, I understand that I might not be accepted into Circle of Friends Adult Day Services program after the provisional period for the following reasons:

1) I do not respond to the program.

2) I have some behavior(s) that interfere with the operation of the program.

3) I experience a physical or mental condition that indicates another level of care.

In addition, I understand that if I have any living habit or behavior that is disruptive to the group that my continuance in the program will depend upon my correcting this problem. I understand that Circle of Friends Adult Day Services and my family will work with me to correct difficulties, and failing improvement, I will be discharged from the program.

_____ _____

Date Signature of Participant or Guardian

Release of Information

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I _____recognize that by initialing and signing this release, I am

1. _____ **Release of Responsibility**

   I would like to attend Circle of Friends Adult Day Services and participate in the regularly scheduled activities. I acknowledge my participation in all activities sponsored by Circle of Friends Adult Day Care Services as voluntary and will not hold the Center nor any employees or volunteers responsible for any illness or accidents which may occur while I am a participant in the program. I understand that any financial liability incurred due to transport, treatment or extended care resulting from an accident or illness while in attendance at Goodwill Adult Day Care is my sole responsibility.

2. _____**Consent for Release of Information**

   I hereby allow the release of any of my information to the following individuals:

   1. Case Manager: _____
   2. Other: _____
   3. Other: _____

   I understand that only the above listed individuals will be given information pertaining to this participant. I understand that I am responsible for keeping this list up to date and do not hold responsible Circle of Friends Adult Day Services if I fail to do so.

3. _____ **Consent for Release of Medical Information**

   I hereby authorize the release of my medial and other information related to my health to Circle of Friends Adult Day Services. I understand that my medical history will only be used for the professional purpose and will be held confidential.

4. _____ **Emergency Medical Treatment**

I hereby authorize consent for medical treatment, in the case of an emergency, by the nearest medical facility. It is the policy of Circle of Friends Adult Day Services that permission is granted to receive medical care treatment, so no delay in care arises during the case of an emergency.

5. _____ Photo Release

I hereby authorize Circle of Friends to photograph and video record me engaged in activities during in-house and community events and to utilize these images in newsletters and promotional materials.

6. _____ Consent / Waiver to Participate in Activities

I hereby release Circle of Friends from any liability that may arise when participating in day programming activities such as community outings, recreational activities, and skill development activities.

7. _____ Transportation Consent / Waiver

I consent to transportation via agency van or public transportation to and from community activities. I hereby release Circle of Friends Adult Day Program Services from any claims that may arise in said regards.

_____ _____

Date Signature of Participant or Guardian

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Health Report

Circle of Friends ADS shall require that each participant, before admittance into the program, present a statement from a physician indicating that the participant does not have any communicable disease, illness or disability, which would interfere with the participants ability to participate in the program.

Instructions: Circle of Friends ADS shall provide each participant with a copy of this form to be taken to a health care provider. A signature on the bottom of the document by a health care provider establishes compliance with above requirements. This form is required to be filed in the participant record with Circle of Friends ADS.

<table>
<tr><td colspan="2">Name: (First, MI, Last)</td><td>Date of Birth:</td></tr>
<tr><td>Date: MANTOUX Tuberculin Skin Test</td><td>Date: MANTOUX Tuberculin Skin Test Results</td><td>If the test was positive, was a chest X-ray completed?
_____ Yes ____ Not</td></tr>
<tr><td colspan="3">Comments:</td></tr>
<tr><td colspan="3">AUTHORIZATION</td></tr>
<tr><td colspan="3">I certify, based upon my examination that this person appears to be free of disability, communicable disease or illness transmitted through normal contact, which would interfere with the staff person's ability to participate in program and program activities.</td></tr>
<tr><td colspan="2">SIGNATURE- Physician or Health Check Provider</td><td>Name- Examination Health Professional (Type or Print)</td></tr>
<tr><td colspan="2">Address- Health Professional's Office (Street, City, State, Zip Code)</td><td>Date- Examination</td></tr>
</table>

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Medication Administration For Circle of Friends ADS

Circle of Friends ADS is a state licensed Adult Day Care Program that provides a broad spectrum of day program services to meet the needs of individuals with a wide range of disabilities. Before Circle of Friends ADS staff can dispense or administers a prescription medication to a participant the program must obtain a written order from the physician who prescribed the medication specifying that Circle of Friends ADS staff are permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. Circle of Friends ADS will keep the written order in the Participant's file.

According to the Medical Wavier 202.06 (4)(2) A Participant shall control and administer his or her own medications except when the Participant is not able to do so, as determined by the Participant's physician.

I _____, Primary Physician

for _____, have determined the following:

_____**The participant can control and administer their own medication.**

_____**The staff at Circle of Friends ADS will assist the participant with their medications. It is understood that they will keep record of all medication given including dose, time and conditions of medications administered. I will also provide Circle of Friends ADS with a copy of all medication orders that they will keep in the participants file.**

Circle of Friends ADS staff are permitted to administer the following medication to:
Patient Name: _____ Sex: _____ DOB: _____

Mediation / Dosage	Times to be given/frequency

I authorize Circle of Friends ADS personnel to assist in the administration of medications described above to the participants named above.

Physician Signature_____Date_____

Office Address: _____ Phone #:_____

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Intake Assessment

Participants Name: _____ **Date Completed:** _____

Functional Level							
Sight		Not Impaired		Impaired		Blind	
Hearing		Not Impaired		Impaired		Deaf	
Speech		Not Impaired		Impaired		Aphasic	
Comments:							

Activities of Daily Living				
	Self	With Assistance	Total Assist	Comments
Eating				
Toileting				
Menstrual				
Urinary	Continent	Incontinent	Catheter	
Bowel	Continent	Incontinent	Colostomy	
Bathroom Schedule Needed				
Mobility	Ambulatory	Cane/Walker	Wheelchair	
Mobility Assistance		1 Person	2 Person	Total Assist
Comments:				

Dietary Needs
Special Dietary Need/Restrictions/Food Allergies:
Adaptive Equipment Needed for Eating / Drinking:

Psychosocial/ Behavioral Level				
	Never	Occasionally	Frequently	Comments
Wanders				

Noisy				
Disoriented				
Withdrawn / Depressed				
Combative				
Delusional				
Impaired Judgment				
Sexual Behaviors				
Displays Inappropriate Behavior (Identify Behavior)				

Fall Risk Screening
How many times have you fallen in the past year? _____
Are you worried you might have a fall? Not At All A Little Somewhat Very
Can you say what makes you more likely to fall?
Any serious injuries in the last year?

List Medication / Dosage / Time		

Safety
Is there a concern that the participant will wander from the group?
Will the participant recognize belongings?
Is participant able to recognize danger?
Will the participant be able to participate in group activities?
Other safety concerns?
Personality
What activities/things frustrate the participant?
What is the best way to engage the participant in activities?

What kind of activities does the participant like to participate in?
What is the best strategy that can be used to redirect participants' negative behavior(s)?
What is the best strategy that can be used to reinforce positive behaviors participant?
Is there any additional assistance we can provide to the participant to support success in the day program setting?

Day Program Activities of Interest					
	Cooking and Baking		Gardening		Grooming
	Arts and Craft		Board Games		Puzzles
	Music		Bingo		Mobile Library
	Community Outings		Computers		Exercise
	Movies		Pet Therapy		Birthday and Holiday Celebrations
	Guest Entertainers		Spiritual Opportunities		Socialization
	Therapy		Health Monitoring		