Helping Hands
Adult Day Program

Enrollment Application

Applicant Information

Client Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apt/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Mailing Address: _____
Street Address *Apt/Unit #*

_____
City *State* *ZIP Code*

Email Address: _____

Phone: _____

Conserved? YES ☐ NO ☐ Date of Birth and Age: _____

Advanced Directive? _____ Do you want assistance to create an Advanced Directive? _____

Veteran? _____ If yes please provide SSN at Intake Assessment

Marital Status? (circle one) **Married/ Widowed/ Single (Never Married)**

Caregiver Information

Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apt/Unit #*

_____
City *State* *ZIP Code*

Text OK? YES ☐ NO ☐ Cell Phone: _____

Phone: _____ Email _____

Caregiver Status

Conservator ☐

Family ☐

POA ☐

Other (explain): _____ ☐

Emergency Contacts

Name/
Relation: _____ Phone: _____

Name/
Relation: _____ Phone: _____

Name/
Relation: _____ Phone: _____

Name/
Relation: _____ Phone: _____

Medical Information

Primary Physician Name: _____ Phone: _____

Dentist Name: _____ Phone: _____

COVID-19 Vaccination Status: ___ Fully* Vaccinated (2 shots) ___ Fully w/ Booster ___ Unvaccinated
*Participants are required to be fully vaccinated to attend program.

ALLERGIES (Drugs, environmental, food, other):
_____

_____

All Current (in the last year) Medical Diagnosis: _____

Any recent hospitalizations? _____

Special Needs
Check all that apply:

___ Assistive Device (W/C, Walker, Cane, Other: _____)
___ Wears Hearing Aids ___ Wears Glasses ___ Wears False Teeth (Full/Partial Dentures)
___ Assist with MOBILITY (Unsteady)
___ Escort to bathroom
___ Wears Depends
___ Hearing Impaired
___ Assist w/ Meals
___ Choke Risk
___ Special Diet:
(_____)
___ Limited Fluid
___ Encourage Fluids
___ Other: (_____)
___ Visually Impaired
___ Cognitive Impaired
(describe)

Description of any impairments: _____

_____

Participation

Check all that apply:
___ Group Exercise (dancing, walks, bowling, chair yoga, etc.)
___ Individual Exercise (supervised)
___ Activities (arts, crafts, baking, gardening, puzzles, table and/or card games, BINGO, etc.)

In the event of a LIFE-THREATENING EMERGENCY

Check ONE: ___ **YES: Begin CPR & Call 911**
___ NO CPR, client is DNR, Call Caregiver

In order to be honored, client must have physician signed DNR on file.

Medications
Please List all medications taken and mark those needed to take during program hours.
In case of emergency a list of medications will be given to the responding EMTs, if not DNR.

Medication name/Dosage	Time Taken	During Program (Y/N)

Please attach list if more than boxes allow.

Does client require assistance with medication? **Y/N**
If Yes Please sign the box below.

MEDICAL ADMINISTRATION PERMISSION

I give permission for the Registered Nurse at Helping Hands Adult Day Program to assist my participant with their medication(s) as instructed. I will send their medication(s) in a prescription bottle marked with their name and time of administration. Per State Regulations, all medications are kept locked in the medication and distributed to the participant at the schedule time.

Responsible Party Signature: _____ **Date:**_____

Attendance Information

1.) Expected days of attendance each week: **Monday** ___ **Tuesday** ___ **Friday** ___
2.) Mode of transportation: **Personal** ___ **Gold Country Lift** ___ **Other (specify):** _____
3.) Will there be any instances of drop-in hours? (These are billed as limited by the hour rates that are other than their normal attendance.) **Yes** ___ **No** ___

Photo/Media Release

- For ID purposes, Participant MAY have their photo taken? Yes___ No___

I give permission to Helping Hands Adult Day Program and the Penn Valley SDA Church to take photographs and/or videos of (participants name) _____ for the purpose of promoting this program though all forms of media marketing, including, but not limited to, printed materials, social media, internet sites, or television.

Responsible Party Signature: _____ Date:_____

Financial Information

- **Our program fee is $65/day, which is the current national average cost for Adult Day Care Programs.**
- **We offer a Sliding Scale Fee Option to those who qualify.**
- **We also accept Participants on an hourly basis if needed.**
- **We accept VA benefits and California Alta Regional qualified individuals.**
- **Sponsorship <u>may</u> be available. Inquire if you think you may qualify.**
- **We are committed to helping every family find a financial solution that works!**

1.) Does client currently have Medi-Cal? ___ Yes ___ No
2.) Do you have another respite care payment option available? ___Yes ___No

___ Long-tern Care Insurance
___ Del Oro Resource Center Voucher
___ Hospice or Transitions Voucher
___ Alta Regional

___ Other: _____

All participating families are expected to make a commitment to contribute to Helping Hands for us to continue to serve our community. If you need assistance, proof of annual income may be required. Request a Financial Assistance Application Form if you think you may qualify.

- **Eligible participants may begin attending immediately.**
- **Enrollment Information Form (this one) MUST be completed to begin.**
- **Out Social Worker WILL make an appointment with you to complete enrolment.**
- **That appointment can take place at our program OR in your home.**
- **COVID-19 Vaccination verification MUST be provided to start and/or visit the program.**
- **The physician's form and TB (PPD) testing results must be completed and submitted within 30 days of participant attending program.**
- **To protect everyone, participants exhibiting symptoms of illness at anytime are asked to stay home or may be sent home if our staff determines they are possibly contagious.**
- **7-day quarantine and/or a negative COVID-19 Test are required for return to program after illness regardless of vaccination status.**

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Responsible Party Signature: _____ Date:_____