**First: Fill out your funding application to the best of your knowledge.**

**Then: return it with your application packet to Trucare Adult Daycare, we will begin processing to gain funding as soon as possible.**

**Thank you for taking the time to check out our daycare. This application packet contains a step-by-step instruction sheet to help make the process easy.**

**For additional help, please contact:**

**Trucare Adult Daycare**

**1068 Arlington Road North**

**Jacksonville, Fl. 32211**

**(904) 527-1254**

***The Support You Need***

|  |  |  |
| --- | --- | --- |
| A picture containing person, indoor  Description automatically generated  **Welcome to trucare adult daycare** |  |  |

**Admission Criteria**

Participants requesting admission must be categorized as:

* Individuals with diagnosis of dementia or other related disorders determined by medical assessment including CT scan, neurological exam, and blood tests. Or:
* Individuals over age 18 with learning challenges experiencing decreased awareness, confusion, disorientation, withdrawal, paranoia, memory impairment, loss of social skills, and/or increased dependency, who need a protective environment free of health and safety hazards.
* Individuals who have been admitted for a 30-day probational period in which they have shown that they have adjusted to the environment, and it is beneficial to them
* All participants **must** have:

1. A negative TB test or chest X-ray done within 45 days of acceptance into the program
2. Completed Medical Statement form
3. Completed Agreement Contract
4. Completed Client Information Data
5. Medication Administration-Supervision Permission if applicable

**Attention:**

Trucare Adult Daycare shall not be deemed responsible for the loss of money, or any other valuables that are brought to the program.

The Trucare Adult Daycare Center’s eligibility guidelines and program policies have been discussed with both the client and/or family and friends. My signature below, shows that I understand this information and agree to comply with these policies.

Applicant’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Family/Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daycare Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s initials: \_\_\_\_\_\_\_\_\_\_

**Applicant Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN:** \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ **Religion:** \_\_\_\_\_\_

**Sex** (circle) **M F Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_**

**Place of birth** (city/state): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status** (circle**): Married Single Divorced Widowed Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**With whom does applicant live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant Health History**

*List any major operations, chronic illnesses, and medical conditions:* \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred hospital:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare/Insurance Information:**

* **Part A**
* **Part B**
* **Other insurance coverage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Admission p. 2 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What assistance is required in the following areas?**

* **Walking, standing EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Bathing EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Toileting EXPLA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Eating EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dietary Requirements:**

* **Regular diet**
* **Low sodium**
* **Diabetic**
* **Other EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Current medications** | **Dosage** | **Times Given** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |

**Is supervision or help required with medications? Yes No Explain** (if yes)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Requested starting date: \_\_\_\_\_\_\_\_\_\_\_Days: (circle) Monday Tuesday Wednesday Thursday Friday**

**Transported by: City Family Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Transportation assistance required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What additional special needs does the applicant have?** (i.e., need for socialization, supervision, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food Preferences:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Beverage Preferences:** \_\_\_\_\_\_

**Assistive Devices:**

**Hearing aid \_\_\_\_\_ Dentures: \_\_\_\_\_ Colostomy \_\_\_ Brace \_\_\_\_\_ Glasses \_\_\_\_ Wheelchair/cane**

**Walker \_\_\_\_\_ Other prosthesis**

**Does the client have bladder control? \_\_\_\_\_\_\_\_\_\_\_\_\_ Bowel control? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Occasional incontinence**
* **Frequent incontinence**

**What are the clients’ interests/activities?**

**Gardening \_\_\_\_ TV \_\_\_\_\_ Sewing \_\_\_\_ Cooking \_\_\_\_ Pets \_\_\_\_ Sports \_\_\_\_ Exercise\_\_\_\_\_ Other \_**

**Smoke: \_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_ Drink alcohol: \_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special Hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name, address, and phone number of individual or agency responsible for payment of adult day care services**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_**

**Applicant Initials: \_\_\_\_\_\_\_\_\_**



100 N. Myrtle Ave. Bldg. G

Jacksonville, FL. 32204

904-265-6001

Thank you for inquiring about eligibility for ADA Paratransit Services. Enclosed is a copy of an ADA Paratransit Application form. Please read the following information before completing the application.

The JTA offers two categories of transportation: the mass transit system (city bus, Skyway, Community Shuttle and Ride Request services) and the JTA Connexion (paratransit service). The JTA’s mass transit service provides accessibility features that make it possible for people with different types of disabilities to ride on its buses, Skyway trains and vans. These include: lifts and ramps (there is no need to use the steps if they cause you problems); tiedowns and passenger restraints (Driver-secured) for people using wheelchairs; stop announcements by the drivers and/or the Talking Bus automatic announcement and information systems for visually and hearing-impaired riders; and route schedules and information in alternative formats.

The JTA also offers to riders who may have a disability, receive Social Security Income or a Disabled Veteran the opportunity to ride the fixed route bus at a reduced rate. You can inquire about this program at 265-6001. In addition, if you are over the age of 65 you qualify to ride the fixed route bus for free. The JTA Connexion is paratransit service that offers door-to-door service to eligible individuals who, due to disability, cannot access the mass transit system some or all of the time.

This application is for certification to use the JTA Connexion service. This application consists of three sections: General Information; Americans with Disabilities Act (ADA) and State Transportation Disadvantaged (TD). Please be sure to fill out the application completely. An incomplete application may delay the processing and/or result in an inaccurate assessment of your abilities.

**When you complete the application and have gathered any supporting documentation as requested you must call the Eligibility Office at 265-6001 to schedule an appointment for your in-person interview and functional assessment**. During this assessment, you will meet with a staff member for an interview where they will ask additional questions concerning your ability to use the JTA, buses, Skyway and vans. Following your interview, you will meet with a professional Functional Assessor for your functional assessment. This assessment will evaluate your travel abilities and limitations. You must bring all mobility devices that you use to travel outside your home and dress accordingly for the weather as some portions of the assessment will be conducted outside. Also, **please bring a picture ID**. We will take your photograph to be used for an ID if you are deemed eligible. Once the interview and assessment are complete, you will receive your determination by letter within 21 days.

**Professional Verification Contact Form**

**For Applicants with Psychiatric Disabilities**

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Professional Contacted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* In what capacity do you know the applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How long have you known or worked with the applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When did you last see or treat the applicant prior to this visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What is the formal diagnosis of the applicant’s disability (DSM V or other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What is the date of onset? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What is the prognosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is the applicant taking any psychotropic, antidepressant or other medications prescribed by you or other medical professional? Yes or No
* If yes, please list the type, frequency, dose, and any comments about how the medication(s) may complicate the individual’s independent mobility in the community.

|  |  |  |
| --- | --- | --- |
| Medication Type | Dosage | Effect on Functionality |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

* If the applicant takes his or her medication compliantly, will independent travel be possible? Yes or No or N/A

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Does the medication have any side effects that would affect the applicant’s use of public transportation? Yes or No or N/A
* Does the applicant experience decreased functionality due to the medication?

Yes or No or N/A

If yes, please explain type and duration of decrease in functional ability. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Does the applicant currently experience tactile, visual, or auditory hallucinations?

Yes or No or N/A

* If yes, would he/she be likely to experience auditory or visual misperceptions due to hallucinations? Yes or No or N/A

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* List and explain any skills affected by the client’s disability. Describe the effect and extent of limitation caused by the disability. Is the applicant able to:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Skills affected | Yes | No | Sometimes | Comments |
| Travel outside the house |  |  |  |  |
| Leave the house on time |  |  |  |  |
| Following directions |  |  |  |  |
| Find way to/from the bus stop |  |  |  |  |
| Crossing the street |  |  |  |  |
| Waiting on the bus |  |  |  |  |
| Boarding the correct bus |  |  |  |  |
| Riding the bus |  |  |  |  |
| Exiting at the correct destination |  |  |  |  |
| Boarding a connecting bus |  |  |  |  |
| Time monitoring |  |  |  |  |
| Dealing with unexpected situations |  |  |  |  |

* Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are any of the following affected by his/her disability? If yes, please explain:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Area | Yes | No | Sometimes | Comment |
| Judgement |  |  |  |  |
| Problem solving |  |  |  |  |
| Insight (problem recognition) |  |  |  |  |
| Coping skills |  |  |  |  |
| Short term memory |  |  |  |  |
| Long term memory |  |  |  |  |
| Concentration |  |  |  |  |
| Orientation |  |  |  |  |
| Communication |  |  |  |  |
| Attention to task |  |  |  |  |

* Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Would training, driver assistance, or tools such as ID cards, printed route direction etc., help to minimize the effects listed above? Yes or No or N/A

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Is independent travel an achievable goal within the context of treatment?

Yes or No or N/A

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Would therapeutic goals be conflicted if alternate forms of transportation (ADA paratransit) are offered/used? Yes or No or N/A

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Does the applicant display aggressive, shy, or other socially inappropriate behaviors?

Yes or No or N/A

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* What are the applicants daily/routine activities and current travel destinations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is the applicant permitted to drive? Yes or No Driver’s license? Yes or No
* Does the applicant lack any life skills that prevent him/her from travel on a fixed route bus? If yes, please describe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Please list any other information that may be an indication that the applicant is unable to use the services of a fixed route bus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I hereby certify that I am familiar with the applicant and his/her functional abilities and the information I have provided above true. I understand that false certification may be reported to the appropriate jurisdiction responsible for state licensing/certification.*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License/Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Professional:

* Psychiatrist
* Psychologist
* Social Worker

**Professional Verification Contact Form for Applicants with Seizure Disorder**

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Professional Contacted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In what capacity do you know the applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Length of time known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Applicants affect prior to seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Applicants affect post seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Frequency of seizures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Does applicant report an aura prior to seizures?

* Yes
* No
* If sometimes, does the client have sufficient time to ensure safety before the onset? Yes or No

1. Are there triggers to these seizures?

* Yes
* No
* N/A
* Comments: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Describe any triggers: If none, list N/A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is client able to travel alone in the community?

* Yes, when, and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

1. Is the applicant allowed to drive?

* Yes
* No

1. Is the applicant taking any medications?

* Yes
* No

1. If yes, please list type, frequency, and dosage

|  |  |  |
| --- | --- | --- |
| **Medication Type** | **Dosage** | **Effect on Functionality** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**\*\*\* We do not dispense medication but will supervise while self-administered.**

* If the applicant takes his or her medication compliantly, will independent travel be possible? Yes or No or N/A

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Does the medication have any side effects that would affect the applicant’s use of public transportation? Yes or No or N/A
* Does the applicant experience decreased functionality due to the medication?

Yes or No or N/A

If yes, please explain type and duration of decrease in functional ability. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I hereby certify that I am familiar with the applicant and his/her functional abilities and the information I have provided above true. I understand that false certification may be reported to the appropriate jurisdiction responsible for state licensing/certification.*

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License/Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Professional:

* Physician
* Neurologist
* Social Worker

**Individual Funding Contract**

All individuals with funding accounts are limited to the time specified in their funding accounts set forth by Trucare Adult Daycare. Any time spent in the facility, that exceeds the amount allotted in the funding contract, will incur charges based on the regular program charges of Trucare Adult Daycare program. The caregiver, family member, or applicant will be deemed financially responsible for these charges, at a rate of $10 per hour.

Caregiver signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Applicant initials: \_\_\_\_\_

**Important**

The next five pages are medical release forms, and it is vital that they all be completed. These forms serve to indicate if your loved one has any health conditions or communicable diseases. This information helps us to provide the best care possible for you loved one.

\*\* Your doctor may fill out form A (It is a state medical release form)

Or form B (Trucare’s Medical Release Form) both forms are acceptable.

\*\*Chest X-Rays: Acceptable for up to one year after X-Ray

\*\*TB Test: Acceptable for 45 days after test completed

**Form B**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been found free form TB in a communicable state as demonstrated by:

* PPD
* X-Ray

The above named is free of signs and symptoms of other communicable diseases.

Physician’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Applicant’s initials: \_\_\_\_

* Initial visit
* Annual visit **Form B**

**Physician’s Orders**

Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Medicare number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Current Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Physical
* Mental

|  |  |  |
| --- | --- | --- |
| **Medication Type** | **Dosage** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Applicant Initials: \_\_\_

**Form B**

* I certify that the patient may self-administer \_\_\_\_\_(initial)
* I certify that medication may be given as listed above \_\_\_\_

**\*\*We do not administer medication but will supervise if self-administered.**

**Mobility:**

* Cane
* Walker
* Wheelchair
* Ambulatory

**Physical Limitations:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Abuse/Neglect:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet:**

Regular Low salt

Ground Puree

Low fat Low Sugar

Diabetic (if yes, please provide menu)

**Allergies**

* Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vital signs:**

Blood pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_ Respiration: \_\_\_\_\_\_\_\_\_\_\_\_

**Communicable Disease:** (Tests must be done within 45 days prior to enrollment with Trucare Adult Daycare).

Communicable Disease Present?

Yes \_\_\_ No \_\_\_

**TB Test:**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chest X-Ray:**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have any active diseases such as HIV, HPV, Hepatitis B, or other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Health and Safety Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Office Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_

* Client may be at risk for institutionalization if not admitted in an adult daycare program
* Medication changes require a new order that will be sent to you

Physician’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Initials: \_\_\_\_\_\_\_\_\_\_

**Release Form**

* Client
* Responsible relative
* Guardian
* Other relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize consent to said client’s use of the facilities, and equipment provided by Trucare Adult Daycare Center. I/We also release Trucare’s officials, agents, employees and/or other person, firm, or corporations charged or chargeable with responsibility or liability, from any and all claims, demands, damages, costs, expenses, loss of services, actions, and cause of action, which could arise out of any act or occurrences, and particularly on account of any personal injury sustained by said client, while said client is on any premises/facilities/vehicles operated by Trucare Adult Day care Center.

**Authorization is also granted:**

1. To any physician, hospital, clinic, or medical service for the release of medical and/or psychiatric information on said client to Trucare Adult Daycare.
2. To any Social Service agency for the release of information to Trucare Adult Daycare regarding its contact with said client.
3. For the release of any necessary information on the said client by Trucare Adult Daycare to its agencies and/or medical equipment personnel to obtain appropriate requisite services.
4. For the use of publicity releases of photographs of activities involving said client.
5. To Trucare Adult Daycare Center to secure any emergency medical service as needed if I cannot be contacted immediately.

Preferred hospital is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Doctor is: \_\_\_\_\_\_\_\_\_

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relative Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rate Agreement**

Individuals funded by outside sources are subject to contract agreement. Daily rates will be based on the contracted rate with the funding source. Funded clients must have current service authorization on file. Scholarships may be available for non-funded clients.

* Private pay $70 for 1-8 hours
* Drop-in rate $10 hr. +$4 for meals
* Late Pick-up Fee $35 first 5 mins, $5 per minute after
* Payment is due at beginning of the week/Month (**Prepaid before service**)
* 24-hour notice is required if not attending for a day
* Refunds are credited to the following weeks total

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily Rate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I have received a copy of Trucare Adult Daycare’s center policies
* I hereby comply with the stated policies and procedures there-in
* I will respect the rights, privacy, and property of the other participants

**The client agrees to attend \_\_\_\_ days a week, for a minimum of four hours.**

Client/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Initials: \_\_\_\_\_\_\_\_

**Admission Agreement**

The Trucare Adult Daycare Center agrees to offer needed adult day health services including, but not limited to, nutritional services, recreational activities, social services, and nursing services by a registered nurse (RN) or licensed practical nurse (LPN) when an RN is not available.

To benefit from these services, the client agrees to be in attendance for days agreed upon for the duration.

**No services will be offered on closure days such as:**

* New Year’s Day
* Good Friday
* Memorial Day
* Independence Day
* Labor Day
* Thanksgiving
* Christmas

For any other closures due to inclement weather or other unplanned event, announcements will be broadcasted on First Coast News. (Channel 12 and 25).

**\*\*\*We comply with Duval County Closures**

Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Procedure**

In case of an emergency, which may include hurricane, fire terrorism or any act of God or nature. The following procedure will be followed:

* First Coast News will be notified of any closures
* All clients will be escorted home
* If client cannot be transported home, they will be transported to:

Affordable Training

7867 Lakeland Street,

Jacksonville Fl. 32211

**Important:**

Please ensure that you have filled out the forms necessary for emergency transportation or evacuation, in case of a disaster. They are:

* Evacuation Transportation to a shelter
* Intent of staying in a shelter in the event of a disaster

Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Transportation Protocol**

If transportation is provided through a company, please follow these guidelines:

* Be ready 20-30 minutes prior to pick up time
* Be dressed, groomed, and use the restroom prior to arrival of transport
* Assist with loading and unloading of the individual to and from the vehicle
* Upon pick-up, the transport will only wait for 5 minutes before leaving
* There may be delays due to traffic or weather
* Call and ask for arrival time, if your transport is late for pick up or drop off.

**Meals**

* We provide lunch and assist those who bring their own lunches. Our meals meet 1/3 of the minimum daily requirement.
* We provide afternoon snacks for those still in attendance at 3:30 p.m.

Applicant’s initials\_\_\_\_\_

Memo

Adult Day Health Care (ADHC) is an alternative to nursing home placement. The program is open to elderly individuals, including those with physical and memory problems, as well as individuals 18 years and older, who may have special needs. ADHC provides a therapeutic, protective, structured, and supportive environment five days a week, on a regular basis. One of the local agencies that provide ADHC is Trucare Adult Daycare Center. Trucare Adult Daycare Center is open ten hours a day, Monday to Friday, from 7:30 a.m. to 5:30 p.m. Our services include:

* Social interaction
* Professional and peer support
* Exercise and Mental stimulation
* Health monitoring
* Assistance with eating, toileting, walking and medication

We also of offer structured activities such as:

* Music
* Art
* Reminiscence therapy

**\*\*\*We observe an open-door policy**

**Program Policies**

* **Hours of Operation:**

We are open from 7:30 a.m. to 2:00 p.m. Monday through Friday. Closing will occur promptly at 2:00 p.m. A late fee of $10 every 15-minute increment, will be assessed for individuals not picked up at 2:00 p.m.

* **Incontinence**

Protective undergarments are acceptable for loss of bladder control. Please provide at least 2 per day.

* **Special Assistance**

Our staff is available to aid all our clients. If more than one staff member is needed to provide simultaneous support, this is done on an individual basis, per request.

* **Hygiene Standards**

Clients are required to practice good hygiene (clean clothes, body, hair, teeth and nails). If client is in poor hygiene, we provide referrals, education and/or individual attention.

* **Medication**

Medication brought to us must be:

* Properly labeled with name of medication and dosage
* Have the client’s name
* Pharmacy number, prescribing doctor
* In the correct container as given at the pharmacy
* Kept on the premises while client is in our care

If the client refuse to take the medication, the caregiver will be notified. All refills are the responsibility of the client and/or caregiver.

Applicant/client’s initials \_\_\_\_\_\_

* **Bed Rest**

We provide a day bed for clients who may need to lie down or rest. We also provide easy chairs, recliners, and couches for client’s relaxation.

* **Activities**

We provide a variety of activities both structured and unstructured for our clients to enjoy. All are encouraged to participate.

* **Wandering**

Caregivers should ensure we are notified if the client is prone to wandering. Determination of appropriateness will be made on an individual basis.

* **Combative Behavior**

Trucare Adult Daycare prohibits any hostile, abusive or combative behavior of any kind. These behaviors may be grounds for termination unless they can be controlled by medication and/or behavior management.

* **Termination from the program**

Trucare Adult Daycare operates on policies that promote a healthy, pleasant, and stimulating environment for both client’s and staff. If a client violates these standards, they will be re-evaluated to determine cause for termination from the program, and a conference will be scheduled to discuss the situation. A one week notice to terminate will be given if the client will be terminated.

* **Volunteers**

Trucare Adult Daycare utilizes volunteers from the community, local schools, and universities. There are many volunteer opportunities.

* **COVID 24 Hour Release**

Due to the spread of COVID-19, we will not accept any clients that have cold symptoms including:

**\*\*\*We observe an open-door policy**

Hoarseness, coughing, sneezing, runny nose, fever, diarrhea, and vomiting. If you develop diarrhea or vomiting while in our care, you will have a 24-hour period prior to return to the facility. We appreciate your patience and support

Applicant/Client initials \_\_\_\_\_\_

* **The client or responsible party agrees to:**
* Complete or provide all necessary client-related forms prior to admission
* Notify us at least 7 days prior to discontinuing the program
* Provide 2 (labeled) changes of clothing and undergarments to be kept onsite
* Provide incontinence diapers for daily use
* Absolve the daycare of any liability for loss or damage to the client’s personal property or valuables to fire, theft, or other mishaps
* Absolve Trucare Adult Daycare’s officials, employees, and/or any other person, firm, or corporation charged or chargeable with responsibility or liability from all claims, damages, costs, expenses, loss of services, actions, and cause of action, which could arise out of any occurrence, and particularly on account of personal injury, sustained by the said participant, while the participant is on the vehicles arranged, or owned by Trucare Adult Daycare.
* Authorize the daycare to transport the client off the premises for planned outings, neighborhood walks, or community events, etc. as part of the therapeutic programming.
* Accept the decision of the daycare regarding discharge of the client due to concerns for his/her safety or that of others.
* **Authorize Trucare Adult Daycare to:**
* Use pictures or identifying information regarding the client for publicity purposes or use in an emergency.
* Release information regarding the client for publicity purposes or use in an emergency.
* Transport clients to the nearest emergency facility in the event of an acute illness if family or responsible persons cannot be reached.
* **I agree to:**
* Pay the daycare’s daily rate of \_\_\_\_\_\_\_\_ at the beginning of the week or month and any other fees incurred by me, plus transportation
* Allow the daycare to submit third party billings monthly for services rendered, if necessary/covered.
* That Trucare Adult Daycare hours of operation are Monday to Friday 7:30 a.m. to 2:00 p.m.
* A late charge of $10 will be charged for each 15 minutes past 2:00 p.m. or previously agreed time for client to be picked up.
* Client will attend daycare \_\_\_\_ times per week on:
* Monday
* Tuesday
* Wednesday
* Thursday
* Friday
* **Abuse and Neglect**
* All employees are trained on recognizing and reporting abuse
* Training is given annually
* All employees are given the registry abuse number during training
* If you have any concerns about abuse or neglect, please notify the director.
* My signature below signifies that I have read and understand all the statements above and will abide by them.

Legal Caregiver signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s initials: \_\_\_\_\_\_\_

**Bill of Rights**

This bill reaffirms all those inalienable rights guaranteed in the U.S Bill of Rights while setting forth 12 specific rights for all citizens:

* The right to dignity, privacy, and humane care
* The right to religious freedom and practice
* The unrestricted right to communication
* The right to personal possessions and effects
* The right to education and training
* The right to prompt and appropriate medical care and treatment
* The right to social interaction
* The right to physical exercise
* The right to human discipline
* The right to minimum wage protection and fair compensation
* The right to be free from physical restraint
* The right to the central record

All people have the right to make choices, to learn from those choices by way of exposure to natural life experiences, making mistakes, consequences, and the advice of others.

Persons with disabilities have the right to receive impartial information about choices. Undue, imbalanced, or self-serving influence is not acceptable.

Factors that limit choices, should defer between persons with disabilities and others. People have the right to choose from a variety of supports and services and make changes based on their own needs.

People should be offered threat-free options in relation to their health and safety, and that of others. Additionally, people have the right to choose a qualified provider of any needed service or support.

The choices people make does not diminish the obligation to act in a responsible manner and accept the consequences.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_

**Choice and Empowerment**

(Standard 1. B6-cite 15/16-C. A)

As a provider, I recognize the need for individuals to be encouraged to make their own decisions. I view the individuals I serve, and their families, as partners in meeting the person’s service needs.

I am committed to creating opportunities for individuals to make choices throughout the services I provide. The choice-making ability of everyone served by Trucare Adult Daycare, will be reviewed at the time of first meeting with the person, throughout the support plan year, and annually thereafter during the individuals support plan meeting. Training will be provided in areas of need.

The individual is encouraged to identify his/her choices and needs to share them. Priority outcomes are determined through meeting with the person and other individuals they choose to invite. After this process, an implementation plan is developed within 30 days of beginning a new service and 30 days of the effective date of service authorization. This implementation plan is relative to the support plan that is provided and will assist the applicant in meeting their stated outcomes and ensure health and safety goals are met.

During the support plan year, implementation plans may change based on the applicants’ preferences, if a different approach is needed, or as personal outcomes are met. All applicants are required to fully participate in the development of their individualized plans by choosing the services that are needed, how they are provided, and the outcomes that are desired. Family or friends are utilized if the applicant has difficulty understanding the consequences of making choices.

We further encourage choice making by enlisting our clients to participate in community training activities where they choose their location of preference, and what they would like to purchase.

If a client is not happy with the services we provide, they have the right to choose a new provider. The choice making policy is reviewed annually.

* My rights regarding choice making have been fully explained to me.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_

Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grievance Process**

Every person receiving services, caregiver, parent/guardian has the right to express a grievance to the daycare staff. The staff member will attempt to address the problem.

* If the grievance is not addressed with satisfaction, the grievance may then be taken to the Program Director
* A grievance form is filed at this time
* The Program Director has 7 days to respond to the filed grievance
* If the grievance is still not handled satisfactorily, an appointment with the Director may be requested, at which point there is a 20-day limit to resolve the complaint.
* If the grievance is still not resolved, an appointment with the support coordinator, case manager, or owner operator may be requested. The owner operator will have 10 days to be resolved. The decision will be final.
* This form will be reviewed annually.

Caregiver signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Participant’s Portrait and Video Image**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am aware that staff or visiting photographers and/or videographers will be capturing audio and photo or video footage at this facility during participant activities and special events. By allowing the photographers or media to capture my image or my family members image. I am granting permission to the facility, and its visiting service and activity providers to use my image/my family members image to promote the facility, health activities, the activity service providers, and any associated events. I must inform the media manager, if I do not wish myself or my family member to be photographed or audio/video recorded and must then refrain from being included in such media.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that any media images which may be taken and shared are in the utmost respect for myself/family member and are meant to represent all those involved in the most positive manner. I understand that at no time will this be an attempt to invade any privacy, or share my detailed personal/medical information, or the personal/medical information of my family member with the public or any other business or soliciting entity. I hereby release and hold harmless, in all media or legacy, this facility, the organizers, sponsors, affiliated service providers, visiting entertainers, activity service agents and any supervisors of this media recording effort, from all ties of personal copyright or gains or from media ownership of my image or my family member’s image.

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usable Media Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Optional contact information for media viewing/photo prints:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Record of Disclosures**

Please check all that apply. I wish to be contacted in the following manner:

**Phone**

* Home phone
* Ok to leave detailed message
* Leave only call back number

**Written**

* Written communication
* Ok to mail to my address
* Ok to mail to my work address
* Ok to fax to this number

**Work**

* Work telephone number
* Ok to leave detailed message
* Call back number only **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- |
| **RECORD OF DISCLOSURE OF PROTECTED HEALTH INFORMATION** | | | | | | |
| **DATE** | **DISCLOSED TO** | **(1)** | **PURPOSE OF DISCLOSURE** | **DISCLOSED BY:** | **(2)** | **(3)** |
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* **Check if disclosure is authorized**

**Uses and disclosures of protected health information may be permitted without authorization in an emergency**

* **T**=TREATMENT RECORDS**, P**=PAYMENT INFO, **O**=HEALTHCARE OPERATIONS BY: **F**=FAX**, P**=PHONE, **O**=OTHER