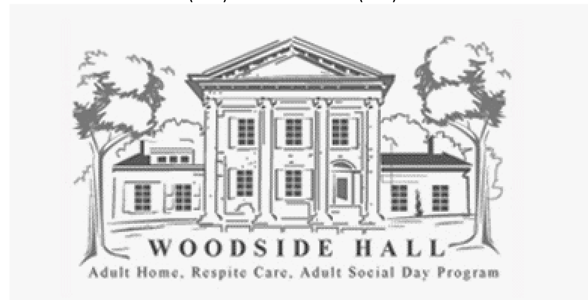
Woodside Hall, LLC
Adult Home/Adult Social Day Program/Respite Care
One Main Street, Cooperstown, New York 13326
Phone (607) 547-0600 Fax (607) 547-0601

These are the steps necessary to become a participant in the Adult Day Program:

We are a New York State certified Adult Social Day Program

- Contact Woodside Hall Adult Social Day Program and arrange for a tour and discussion about what the Program offers and what responsibilities the participant has and if we can meet your needs.
- Meet with the intake person to review the admission agreement and payment arrangements. There is a $200 pre-admission fee.
- Transportation is provided by the participant/care giver, or referral agency. Woodside Hall Social Day Program staff will work with the participant to arrange transportation if needed but Woodside Hall will not be responsible for the payment of the transportation.
- To be admitted you must be cleared by your physician who completes a medical form specifically for the Adult Social Day Program. *(see medical form is included in this packet)* You must have a medical form completed every 6 months, signed by your physician.
- We need written verification of the dates of your of influenza and pneumonia vaccinations, these vaccinations must be current. You must have a TB test within 30 days of admission to the program.
- Woodside Hall staff will provide assistance to obtain these vaccinations, the TB test, or a medical appointment if needed.
- Your physician must indicate that you are able to participate in the program.
- Your physician must complete and sign our Dietary Form.
- Your physician must approve for you to consume alcohol if you wish to participate in our occasional programs that include alcohol. A physicians' statement on his script pad is all that is necessary.
- If you take medication during the program times, you, or the person who brings you must bring your medication with instructions to the program each day.
- Your physician decides whether you are able to take the medication with or without staff supervision.
- If you need supervision, a med staff person will remind you about the medication time and observe you taking your medication. If your physician deems you independent you can take your medication without staff observation.

Once these steps are completed we can give you a date to start the program.



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Adult Social Day Program

Our goal is to provide participants with opportunities to socialize, make new friends and create an environment for pursuing each person's interests. Our program runs every weekday, from 10 a.m. to 3 p.m. and includes a morning and afternoon snack and a hot homemade lunch.

Our Activities Staff and Personal Care Aids coordinate together to help all to have an enjoyable day. Woodside Hall Residents look forward to taking part in the Adult Social Day Program activities. We have wonderful volunteers that share their varied talents.

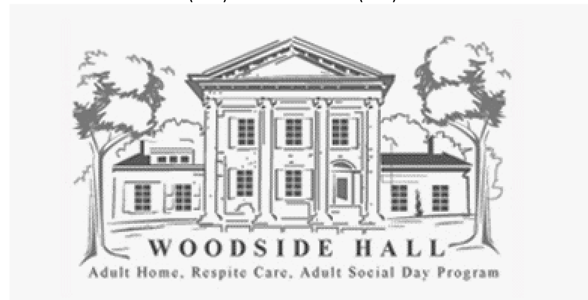
The program fee is $100 a day. There is a $200 pre-admission fee.

To schedule a visit & tour, please contact;

Barbara Sullivan at 607-547-0600, ext. 102

Email: barbarte@verizon.net

Our website: www.woodsidehall.net



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Adult Social Day Program Schedule

(A Typical Day)

10:00 a.m. Morning welcome with choice of coffee, tea or other beverage with morning snack in the dining room.

10:30 a.m. News of the day, trivia game and /or therapy dog visit or sing-a-long

11:30 a.m. Chair Exercises in the dining room

12:30 p.m. Home cooked lunch in dining room

1:30 p.m. Craft or game in the dining room

2:30 p.m. Snack and conversation

3 p.m. Farewells

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STATEMENT OF PURPOSE	DSS-3122 (Revised 12/79) MEDICAL EVALUATION (Resident)		
Adult Residential Care Programs provide 24 hour residential care settings for dependent adults. They are not medical facilities. Persons in need of constant medical care and supervision should not be admitted or retained in an adult residential care facility because such a facility lacks the staff and expertise to provide needed services. Persons who, by reason of age and or physical and/or mental limitations, are in need of assistance with the basic activities of daily living, can be cared for in adult residential care settings. The information solicited in this medical evaluation will assist you, the individual, and the operator of an adult residential care facility in determining the level of care needed to assure the health, safety and well-being of the individual. It will become part of the resident's record and subject to review by the State Department of Social Services, which is responsible for supervision of Adult residential Care Programs.	NAME		
	ADDRESS		
	SEX M F	DATE OF BIRTH	EXAMINATION DATE

SECTION I: **MEDICAL HISTORY**

PRIMARY DIAGNOSIS	
RECENT SURGERY (type of procedure and date)	RECENT ACUTE ILLNESS (type and date)
CHRONIC ILLNESS, PHYSICAL OR MENTAL LIMITATIONS	SPECIAL DIET **Please use/see Diet Order form**
WEIGHT (include opinion regarding overweight, etc.)	BLOOD PRESSURE
ACTIVITY RESTRICTIONS	WEIGHT BEARING (full, partial, none)
REQUIRED PERIODIC OR INTERMITTANT NURSING CARE, AND/OR MEDICAL EXAMINATIONS, DOCTORS' VISITS, OR SKILLED OBSERVATION OF SYMPTOMS:	

SECTION II: MEDICATIONS NEEDED

TYPE, FREQUENCY, AND DOSAGE

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DSS-3122 (12/79) (REVERSE)

SECTION III: OBSERVATION OF INDIVIDUAL

yes	no	Is the individual capable of self-administration of Required medications?	yes	no	Bedfast – Unable to transfer
yes	no	Ambulatory – Without assistance	yes	no	Incontinent (describe)
yes	no	Ambulatory – With assistance	yes	no	Habituated or addicted to alcohol or other substance
yes	no	Chairfast – Able to transfer	yes	no	If yes, is the individual a danger to himself or others
yes	no	Chairfast – Unable to transfer	yes	no	Free of communicable disease
yes	no	Bedfast – Able to transfer			

SECTION IV:

In your opinion does the individual need the support and services available in and adult residential care setting? (please describe fully)

Does the individual require placement in a skilled nursing or health related facility? (give reasons)

PHYSICIANS SIGNATURE	DATE

Woodside Hall
Medical Evaluation Supplementation

As part of the physical evaluation, the **NYS Department of Health** requires Woodside Hall to be aware of the status of your common **yearly vaccinations and PPD's every two years**. Please have the physician complete the section below for our records.

Resident: _____________________________ **Date of Birth** ______/________/________
(resident's name)

PPD test last received on ______/_______/_______ _____________ or Declined (circle if this is the case)
(Date) Results

Flu vaccination last received on _____/_________/________ or Declined (circle if this is the case)
(Date)

Pneumonia vaccination last received on ______/_______/_______ or Declined (circle if this is the case)
(Date)

Pertusis vaccination last received on ______/_______/_______ or Declined (circle if this is the case)
(Date)

Any other vaccinations that should be noted:

Name of Vaccine	Date Given
_______________________	_____________________
_______________________	_____________________
_______________________	_____________________
_______________________	_____________________

Physician signature _________________________________ **Date** _______________________

WOODSIDE HALL, LLC

Resident's request for Prescription and Non Prescription PRN Medications only

- Please complete all of the blank areas below when ordering Prescription and Non Prescription PRN medications.

____________________is capable of making a decision to request the following
(Resident name)
medication(s):

Medication-dosage-route_________________________
As needed for____________. A maximum of____doses may be requested by the resident in a 24 hour period every_______hours.

Medication-dosage-route_________________________
As needed for____________. A maximum of____doses may be requested by the resident in a 24 hour period every_______hours.

Medication-dosage-route_________________________
As needed for____________. A maximum of____doses may be requested by the resident in a 24 hour period every_______hours.

Medication-dosage-route_________________________
As needed for____________. A maximum of____doses may be requested by the resident in a 24 hour period every_______hours.

Physician Signature___________________________ Date signed_______________

WOODSIDE HALL, LLC

Diet Order

1 Main Street/Cooperstown, New York 13326
Phone: 607-547-0600 Fax: 607-547-0601

Date: _______________________________ Dear Dr. ____________________________________

When the time comes to move from home to an adult care setting the transition should be as smooth as possible. Residents residing in this setting desire their living restrictions to a minimum as in their own home.

The goal at Woodside Hall is to liberalize the restrictions of the therapeutic diet prescription to assure both adequate food intake and weight maintenance within the resident's usual body weight while limiting nutrients with negative impact on medical status and disease processes.

Patient/Adult Home Resident: ____
Food Allergies: ____
Food Intolerances: ____

The following diet is offered at Woodside Hall.

- **Regular/ HEART HEALTHY/Diabetic Diet** – ***Foods are prepared NO ADDED SALT (NAS) (<4gm), frozen vegetables are used more frequently than canned, high sodium and fat entrees are kept to a minimum. Fresh fruit, water packed or juice packed fruit are served at 1-2 meals daily. Concentrated sweets (i.e., cake, cookies, pie........) will be planned into a lunch or a supper meal 1x daily. 1% milk is offered. Diet beverages, jelly, syrup etc., will be offered and encouraged to Diabetic and Bariatric residents.***

A swallowing evaluation may be ordered by the physician for a resident/patient if his/her chewing or swallowing ability is questionable or if a specific change in condition warrants re-assessment.

Please circle ***the appropriate food texture for the patient/resident***

Food textures available are:

Regular

- ***All foods are served as prepared***

Mechanical

- ***Certain foods may be chopped or ground depending on the texture and tenderness of the food.***
- ***All foods served on a regular consistency diet may be included.***

Pureed

- ***All foods are pureed before serving.***

Does Resident/Patient require supervision while eating or drinking? Yes _______ No _______

Resident/Patient: May ____ or May NOT _____ have alcoholic beverages at the activities program?

_____1 oz. Liquor ____12 oz. Beer ____6 oz. Wine

Physician Signature ____ Date: ___________________________

Stacia Whitney, RD, CDN, Consulting Dietitian

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PPD Test Results (TB TEST)
Information

Woodside Hall is required by NYS Law to have on record, a PPD Test result, otherwise known as a TB test, from a licensed healthcare provider within 30 days of admission to our residence.

Your licensed healthcare provider will perform this test. Once administered, the injection site must be evaluated within a 48 -72 hour time period to determine results.

A copy of the results will be given to you by the provider and a copy must be submitted to Woodside Hall before you move in.

Please let us know if you have any questions.