Liberty
ADULT DAY HEALTH

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
- Navicare
- Tufts – Senior Care Options
- Senior Whole Health
- Long Term Care Insurance

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

Basic Level of Care: $61.75
Complex Level of Care: $77.75

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. Attach pages for additional information if needed
3. Once complete, mail, fax, scan or email application to the center
4. 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 508-497-2300
Admissions Coordinator x102
Registered Nurse - x 104
Program Director x105

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Admission Screening for Adult Day Health

Personal Information

Applicants Name: _____ Nickname: _____

Address: _____

Phone: _____ Lives with: _____

Date of Birth: _____ Age: _____ Sex: M F Religion: _____

Primary Language: _____ Marital Status: Single Married Divorced Widowed

Do you have: Medicaid/Masshealth If yes, Card # _____

Medicare If yes, Card # _____

Other: Name of Insurance Company _____ Policy # _____

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 _____

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Legal Status- **Provide legal documentation if Legal Guardian/Power of Attorney has been appointed**

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 Not Resuscitate			
Health Care Proxy			
Legal Guardian			
Power of Attorney			

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

Other: _____

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

If determined eligible, how many days a week are you interested in attending? _____

Which days? Mon Tue Wed Thurs Fri

Living Arrangements, Supports and Transportation

Living Arrangements: Spouse _____ Child _____ other, specify_____

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

Lives with: _____ Lives alone _____

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

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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_____Where_____

Psychiatric Hospitalization Date _____Reason_____Where _____

Allergies to medications/reactions_____

Current Medication	Dosage	Times Given/Frequency

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I. Ever Experienced any of the following health problems:

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

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: _____

II. Nutrition

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

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

Troublesome foods: _____ Tea or Coffee with _____

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III. Safety Concerns

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

Please explain the behavior, the triggers and methods to calm the individual:

IV. 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 ☐ Incontinent of stool ☐ Incontinent of both ☐ Needs reminders to go to the bathroom ☐ Uses depends	☐ Walker ☐ Cane ☐ Wheel Chair ☐ Glasses ☐ Hearing Aid ☐ Dentures ☐ Oxygen	

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V. 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 ☐ Post Traumatic Stress Disorder ☐ Other _____	Mood ☐ No issues ☐ Occasional sadness or bouts of crying ☐ Feeling hopeless, lonely ☐ Manic behavior such as overeating, overspending, hyper ☐ Suicidal thoughts	Behavior ☐ No issues ☐ Argumentative or irritable ☐ Withdrawn or unresponsive, obsessive compulsive behavior, aggression/lashing out ☐ Unable to go in public or relate to people
Anxiety ☐ No issues ☐ Fearful of new situations ☐ Physical symptoms such as sweating, increased heart rate, shallow breathing ☐ Constant worrier ☐ Hinders everyday function	Observations to share ☐ Withdrawn ☐ Socially isolated ☐ Agitated ☐ Relationship challenges ☐ Cooperative ☐ Dependent ☐ High stress in proportion to life circumstances ☐ High stress to nature of individual ☐ Paranoid	Sleep ☐ No issues ☐ Occasional complaint of not sleeping or disrupted patterns ☐ Frequent oversleeping ☐ Frequent not sleeping ☐ Sleep interferes with normal functioning ☐ Takes medication to sleep

VI. Coping

Healthy coping methods ☐ Cuddling with a pet ☐ Walking ☐ Friends ☐ Crossword Puzzle ☐ Knitting	Unhealthy Coping methods ☐ Alcohol ☐ Cigarettes ☐ Drugs ☐ Marijuana	Additional Information/Other:

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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

☐ Arts and Crafts ☐ Bingo ☐ Pet Therapy ☐ Singing/Music	☐ Plant Care ☐ Reading ☐ Outings ☐ Writing	☐ Cards ☐ Puzzles ☐ Exercise ☐ Movies	☐ Board Games ☐ Mental Stimulation ☐ Sensory Stimulation ☐ Walking

Other, current activities of enjoyment?

_____

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 _____

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Commitment

Please note that Liberty Adult Day Health is a business geared toward making your loved one comfortable and welcome.

We do need to ask that there is a commitment on the client's part for the time agreed to be spent at Liberty Adult Day Health.

If there is an agreement that your loved one will come anywhere from two to five days, we need this agreement adhered to. If a day is missed we would like our clients to come on another day to make up the time. We completely understand that there are things that come up that will create absences. Upon admission, please bring a change of clothes for your loved one to keep at Liberty Adult Day Health. Each client will receive a personal bin for their change of clothes. Please include 1 pair of pants, shirt, underwear, sweatshirt, socks, and sanitary products/depends if necessary.

Please discuss this with our Admissions Coordinator or our Program Director. Thank you.

_____

Signature Date

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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:** _____

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Massachusetts Return to Day Program Risk/Benefit Discussion Checklist

This tool is designed for use by participants, caregivers, and providers collectively to help inform the decision to return to a day program. Checked boxes should be tallied for each section. **Upon completion,** you will have a visual representation of risks and benefits associated with returning to a day program. Higher tallies in the risk categories indicate a greater risk of poor health outcomes from COVID-19 infections.

Note: This Risk/Benefit Tool is meant to assist participants and their loved ones in determining their comfort level in returning to a day program based on their individual experiences.
There is not a specific designated score that qualifies or excludes a participant from returning to their day program.
Name of Participant: _____Date of Completion: ___/___/_____

Part A: Situational Risks	Check box if present(☒= 1
The participant is not able to follow social distancing protocol with 6 feet of distance	☐
The participant needs prompting/assistance to socially distance	☐
The participant is not able to use personal protective equipment (PPE) for extended periods of time	☐
The participant requires physical assistance or promptingto complete ADLs, such as toileting, eating, or mobility	☐
The participant is not willing or able to answer a series of health screening questions at several intervals throughout the day	☐

Total # of Situational Risks (Part A): _____

Part B: Health Related Risks	Check box if present(☒= 1
The participant has diabetes	☐
The participant is severely obese	☐
The participant is older (increased age = higher risk)	☐
The participant has known respiratory issues	☐
The participant has known serious heart conditions, including	☐

coronary artery disease and hypertension	
The participant has immunocompromising conditions (i.e. HIV, cancer, post-transplant, prednisone treatment, etc.)	☐
The participant has a chronic kidney disease	☐
The participant has any other underlying health problems which could be considered a risk	☐

Total # Health Related Risks (Part B): _____

Part C: Benefits to Participant	**Check box if present(☒= 1)**
Participant cannot be left home alone and supervision at home is likely unavailable	☐
Needs the medical support of day programming (i.e. med admin, medical check-in)	☐
If not in a structured program, the participant may be wandering in the community or engaging in risky, non-distanced activities.	☐
Socialization is important to the participant's health; or, lack of socialization has known serious risks to mental health conditions.	☐
A sense of normalcy/routine is important to the participant's health; or, lack of routine has known serious risks to mental health conditions	☐
Daily activity outside the home is likely to reduce the frequency of behavioral issues	☐
The participant is unable or unwilling to engage in virtual/video programming	☐
Other Benefit(s):	☐

Total # Benefits (Part C): _____

Overall Total Risk Score (Part A + Part B): _____

Overall Total Benefit Score (Part C): _____

***Note**: This Risk/Benefit Tool is meant to facilitate discussion and to assist participants and their loved ones in determining their comfort level in returning to a day program based on their individual experiences.*

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Risk Assessment Acknowledgement Form

I _____ acknowledge that I spoke with Liberty Adult Day Health's nurse or social worker prior to returning to the program. I confirm that I discussed and understand the benefits and the risks associated with returning to Liberty Adult Day Health.

_____

Signature