



Admission Process

Just a few steps to see if our program suits your needs:

1. Visit our center for a tour
2. Fill out an application (submit to Liberty ADH)
3. Clients primary care physician will fill out a medical report (Liberty will fax paperwork to PCP)
4. **Schedule a TB (Tuberculosis) test with your physician TB test and results must be documented within the last two years. Liberty requires negative result before a trial can be scheduled.**
5. Upon admission please bring a change of clothes to be kept at the facility.

***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

Admissions Coordinator - Christine Tobin, LSW x102 or e-mail admissions@hopkintonhealthcenter.com
Registered Nurse - x 104 or e-mail RN@hopkintonhealthcenter.com



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 _____



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 (DNR)			
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)

<input type="checkbox"/> Safety	<input type="checkbox"/> Therapy Services	<input type="checkbox"/> Intellectual Stimulation
<input type="checkbox"/> Socialization/Friendships	<input type="checkbox"/> Nursing Services	<input type="checkbox"/> Caregiver Respite
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Supervision	<input type="checkbox"/> 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 trips with Liberty ADH? Yes or N

Identify current In-home services

<input type="checkbox"/> Nursing	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Home Care Aid	<input type="checkbox"/> 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

I. Ever Experienced any of the following health problems:

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

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
<input type="checkbox"/> Regular	<input type="checkbox"/> Good	<input type="checkbox"/> Chewing	
<input type="checkbox"/> Low Sodium	<input type="checkbox"/> Fair	<input type="checkbox"/> Swallowing	
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Poor	<input type="checkbox"/> Holding utensils	
<input type="checkbox"/> Other			
Explain: _____			

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

Troublesome foods: _____ Tea or Coffee with _____

III. Safety Concerns

<input type="checkbox"/> Flight Risk <input type="checkbox"/> Wanders <input type="checkbox"/> Puts Objects in mouth <input type="checkbox"/> Poor Balance	<input type="checkbox"/> History of falls <input type="checkbox"/> Aggressive towards others <input type="checkbox"/> Aggressive towards self <input type="checkbox"/> Personal Boundaries	<input type="checkbox"/> Inappropriate language <input type="checkbox"/> Sexually acts out <input type="checkbox"/> Destroys property <input type="checkbox"/> 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 <input type="checkbox"/> Incontinent of urine <input type="checkbox"/> Incontinent of stool <input type="checkbox"/> Incontinent of both <input type="checkbox"/> Needs reminders to go to the bathroom <input type="checkbox"/> Uses depends	Medical Devices Used <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheel Chair <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Dentures <input type="checkbox"/> Oxygen	Additional Information:
--	---	--------------------------------

V. Cognitive/Behavioral Status/Mental/Emotional

Applicants orientation <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time	Short term memory <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Long term memory <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Speech <input type="checkbox"/> Inability to word find <input type="checkbox"/> Slurring <input type="checkbox"/> Nonsensical speech	Communication <input type="checkbox"/> Understands verbal direction <input type="checkbox"/> Communicates needs <input type="checkbox"/> Understands written instruction	Abilities <input type="checkbox"/> Read <input type="checkbox"/> Write
Diagnosis <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Anxiety <input type="checkbox"/> Schizophrenia <input type="checkbox"/> OCD <input type="checkbox"/> Post Traumatic Stress Disorder <input type="checkbox"/> Other <hr/>	Mood <input type="checkbox"/> No issues <input type="checkbox"/> Occasional sadness or bouts of crying <input type="checkbox"/> Feeling hopeless, lonely <input type="checkbox"/> Manic behavior such as overeating, overspending, hyper <input type="checkbox"/> Suicidal thoughts	Behavior <input type="checkbox"/> No issues <input type="checkbox"/> Argumentative or irritable <input type="checkbox"/> Withdrawn or unresponsive, obsessive compulsive behavior, aggression/lashing out <input type="checkbox"/> Unable to go in public or relate to people
Anxiety <input type="checkbox"/> No issues <input type="checkbox"/> Fearful of new situations <input type="checkbox"/> Physical symptoms such as sweating, increased heart rate, shallow breathing <input type="checkbox"/> Constant worrier <input type="checkbox"/> Hinders everyday function	Observations to share <input type="checkbox"/> Withdrawn <input type="checkbox"/> Socially isolated <input type="checkbox"/> Agitated <input type="checkbox"/> Relationship challenges <input type="checkbox"/> Cooperative <input type="checkbox"/> Dependent <input type="checkbox"/> High stress in proportion to life circumstances <input type="checkbox"/> High stress to nature of individual <input type="checkbox"/> Paranoid	Sleep <input type="checkbox"/> No issues <input type="checkbox"/> Occasional complaint of not sleeping or disrupted patterns <input type="checkbox"/> Frequent oversleeping <input type="checkbox"/> Frequent not sleeping <input type="checkbox"/> Sleep interferes with normal functioning <input type="checkbox"/> Takes medication to sleep

VI. Coping

Healthy coping methods <input type="checkbox"/> Cuddling with a pet <input type="checkbox"/> Walking <input type="checkbox"/> Friends <input type="checkbox"/> Crossword Puzzle <input type="checkbox"/> Knitting	Unhealthy Coping methods <input type="checkbox"/> Alcohol <input type="checkbox"/> Cigarettes <input type="checkbox"/> Drugs <input type="checkbox"/> Marijuana	Additional Information/Other:
---	--	--------------------------------------



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

<input type="checkbox"/> Arts and Crafts	<input type="checkbox"/> Plant Care	<input type="checkbox"/> Cards	<input type="checkbox"/> Board Games
<input type="checkbox"/> Bingo	<input type="checkbox"/> Reading	<input type="checkbox"/> Puzzles	<input type="checkbox"/> Mental Stimulation
<input type="checkbox"/> Pet Therapy	<input type="checkbox"/> Outings	<input type="checkbox"/> Exercise	<input type="checkbox"/> Sensory Stimulation
<input type="checkbox"/> Singing/Music	<input type="checkbox"/> Writing	<input type="checkbox"/> Movies	<input type="checkbox"/> 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 _____



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



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 of 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:** _____

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(☒=)
The participant is not able to follow social distancing protocol with 6 feet of distance	<input type="checkbox"/>
The participant needs prompting/assistance to socially distance	<input type="checkbox"/>
The participant is not able to use personal protective equipment (PPE) for extended periods of time	<input type="checkbox"/>
The participant requires physical assistance or prompting to complete ADLs, such as toileting, eating, or mobility	<input type="checkbox"/>
The participant is not willing or able to answer a series of health screening questions at several intervals throughout the day	<input type="checkbox"/>

Total # of Situational Risks (Part A): _____

Part B: Health Related Risks	Check box if present(☒=)
The participant has diabetes	<input type="checkbox"/>
The participant is severely obese	<input type="checkbox"/>
The participant is older (increased age = higher risk)	<input type="checkbox"/>
The participant has known respiratory issues	<input type="checkbox"/>
The participant has known serious heart conditions, including	<input type="checkbox"/>

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

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	<input type="checkbox"/>
Needs the medical support of day programming (i.e. med admin, medical check-in)	<input type="checkbox"/>
If not in a structured program, the participant may be wandering in the community or engaging in risky, non-distanced activities.	<input type="checkbox"/>
Socialization is important to the participant's health; or, lack of socialization has known serious risks to mental health conditions.	<input type="checkbox"/>
A sense of normalcy/routine is important to the participant's health; or, lack of routine has known serious risks to mental health conditions	<input type="checkbox"/>
Daily activity outside the home is likely to reduce the frequency of behavioral issues	<input type="checkbox"/>
The participant is unable or unwilling to engage in virtual/video programming	<input type="checkbox"/>
Other Benefit(s):	<input type="checkbox"/>

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.



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