FOR OFFICE USE
Application Received _____
Enroll Date _____

Adult Day Services

APPLICATION MUST BE COMPLETED PRIOR TO ENROLLMENT

Participant General Information

Name: _____ **Preferred Name:** _____

Address: _____ **City/ State:** _____

Zip Code: _____ **Home Phone:** _____

Preferred Days ☐ **M** ☐ **Tu** ☐ **W** ☐ **Th** ☐ **F** ☐ **Any Day** ☐ **First Available**

We will make every effort to accommodate your request but cannot guarantee due to staff / space limitations.

Arrival Time _____ **Departure Time**_____

Primary Goals for Day Program Enrollment

☐ **Socialization** ☐ **Supervision** ☐ **Family Respite** ☐ **Independence**
☐ **Volunteer Opportunities** ☐ **Physical Movement / Exercise**
☐ **Other:** _____

How did you hear about Signal Centers Adult Services?

☐ **Community Agency Referral** ☐ **Community Outreach Event**
☐ **Current Participant Recommendation** ☐ **Internet Search**
☐ **Physician's referral / recommendation**

Participant Personal Information

**** SSN & Medicaid number will only be released to medical personnel in an emergency****

Social Security Number: _____-_____-_____

Medicare Number: _____-_____-_____

Birth Date: _____/_____/_____ **Age:** _____

Participant Demographic Information *utilized for funding / grant purposes*

Gender: ☐ Male ☐ Female ☐ Other (specify)_____

Race: ☐ Black ☐ Asian ☐ Bi-racial ☐ Hispanic ☐ White

☐ Other(specify)_____

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Education: ☐ high school ☐ college ☐ Other _____

Previous Occupation: _____

Workplace:_____

Age at retirement: ____ **Adjustment to retirement:** ☐ good ☐ difficult

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Religion (optional) _____

Veteran: ☐ No ☐ Yes **Branch of Service**_____

Primary Caregiver / Responsible Party Information

Name: _____ **Relationship to Client:** _____

Address: _____

City / State / Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Work Place: _____**Work Phone:**_____

Work Hours: _____

Email Address: _____

Does primary caregiver live with the client? ☐ **Yes** ☐ **No**

If no – what are his / her living arrangements:
☐ **Lives Alone** ☐ **Lives w/ spouse** ☐ **Relative** ☐ **Hired Caregiver**
☐ **Other**_____

Is the billing address the same? ☐ **Yes** ☐ **No (provide information below)**

Billing Name: _____

Billing Address: _____

City/ State / Zip _____

Participant Income Information

☐ Social Security _____ / Month

☐ SSI _____ _/ Month

☐ VA _____ / Month

☐ Food Stamps _____ / Month

☐ Other _____ / Month

Participant Medical & Hospital Information – must be completed

Primary Diagnosis: _____

Secondary Diagnosis: _____

Physician Name: _____

Specialty: _____

Address: _____

City / State / Zip Code: _____

Phone: _____ Fax _____

Hospital Preference: _____ Last Time Hospitalized: _____

Allergies / Phobias: _____

Any Recent Surgeries ☐ No ☐ Yes

Reason: _____

Advanced Directives

Please furnish Signal Centers with a copy of any that may apply.

☐ Power of Attorney ☐ Medical Power of Attorney ☐ Do Not Resuscitate
☐ Conservatorship ☐ Guardianship ☐ Living Will ☐ None
☐ Other_____

Power of Attorney's Name: _____

Emergency Contacts – Authorized to Transport

Name: _____ **Relationship to Client:** _____

Address: _____

City / State / Zip Code: _____

BEST number for Emergency Contact: _____

Authorized to Transport Participant ☐ **Yes** ☐ **No**

Name: _____ **Relationship to Client:** _____

Address: _____

City / State / Zip Code: _____

BEST number for Emergency Contact: _____

Authorized to Transport Participant ☐ **Yes** ☐ **No**

Name: _____ **Relationship to Client:** _____

Address: _____

City / State / Zip Code: _____

BEST number for Emergency Contact: _____

Authorized to Transport Participant ☐ **Yes** ☐ **No**

Please include any additional names on an additional sheet

Participant – Physical Needs

Hearing Impairment

Right Ear: ☐ no loss ☐ some loss ☐ complete loss ☐ hearing aid ☐ refuses to wear aid
Left Ear: ☐ no loss ☐ some loss ☐ complete loss ☐ hearing aid ☐ refuses to wear aid

Visual Impairment

Right Eye: ☐ no impairment ☐ cataracts ☐ implants ☐ other: _____
Left Eye: ☐ no impairment ☐ cataracts ☐ implants ☐ other: _____
Glasses: ☐ yes ☐ no ☐ refuses to wear them

Dentures ☐ yes ☐ no

Upper: ☐ full ☐ partial ☐ no teeth ☐ removable bridge
Lower: ☐ full ☐ partial ☐ no teeth ☐ removable bridge

Mobility

Steady on his / her feet ☐ yes ☐ no
Needs some help ☐ yes ☐ no - Please explain _____
Assistive Equipment ☐ Cane ☐ Crutches ☐ Walker ☐ One on One Assistance
☐ Wheelchair - if using a manual chair, is client able to push self? ☐ yes ☐ no

Transferring

Help required: ☐ none ☐ verbal cues ☐ supervision ☐ physical assistance

Participant - Emotional / Personality

Memory Impairment

☐ Alzheimer's
☐ Dementia – specific type (if known) _____
☐ Learning Disability
☐ Intellectual / Developmental Delays
How long have symptoms of the above conditions been present? _____

Happy	Seldom ☐	Sometimes ☐	Often ☐
Sad / Depressed	Seldom ☐	Sometimes ☐	Often ☐
Quiet	Seldom ☐	Sometimes ☐	Often ☐
Withdrawn	Seldom ☐	Sometimes ☐	Often ☐
Easily Confused	Seldom ☐	Sometimes ☐	Often ☐
Worried / Anxious	Seldom ☐	Sometimes ☐	Often ☐
Outgoing / Social	Seldom ☐	Sometimes ☐	Often ☐
Passive _____	Seldom ☐	Sometimes ☐	Often ☐
Sudden Mood Changes	Seldom ☐	Sometimes ☐	Often ☐

Participant – Activities of Daily Living

Eating

☐ without help ☐ some help _____ ☐ needs prompting to eat
please explain

Diet

☐ Regular ☐ Diabetic ☐ No extra sugar ☐ No extra salt
☐ Other restrictions_____
Does the client have any food related allergies? ☐ yes ☐ no
If yes, please list _____
Does the client have any food dislikes? ☐ yes ☐ no
If yes, please list _____

Appetite

☐ good ☐ poor ☐ eats too fast Other information: _____
Any recent ☐ weight loss ☐ weight gain amount:_____lbs.. ☐ neither

Swallowing

Does the client have problems swallowing his / her food?	☐ yes	☐ no
Does the client store food in his / her mouth?	☐ yes	☐ no
Does the client have problems with choking?	☐ yes	☐ no

If yes, are there certain foods that cause choking? _____

Toileting

Incontinent of Bladder:	☐ yes	☐ no	☐ nighttime only
Incontinent of Bowel:	☐ yes	☐ no	☐ nighttime only
Products used I n daytime:	☐ none	☐ pad	☐ adult diapers
Help required:	☐ none	☐ reminders	☐ supervision
	☐ positioning		

As a social model program Signal Centers Adult Day is unable to provide regular toileting / changing services, staff may provide limited assistance in the occurrence of an accident but if accidents regularly occur it may be cause for discharge.

Dressing

Help required: ☐ none ☐ verbal cues ☐ supervision ☐ physical assistance

Participant – Behaviors *(Please check ALL that apply)*

- ☐ Difficulty communicating wants & needs
- ☐ Difficulty completing sentences
- ☐ Sentences do not make sense
- ☐ Difficulty naming or recognizing people
- ☐ Difficulty concentrating on task or completing a task
- ☐ Takes little or no interest in activities, will not start them by self
- ☐ Often asks the same questions over and over
- ☐ Loses or misplaces objects
- ☐ Has difficulty following simple directions
- ☐ Hoards objects
- ☐ Difficulty using regular utensils, eats with hands
- ☐ Talks to people he / she does not know
- ☐ Demands constant attention
- ☐ Lacks appropriate social skills
- ☐ Engages in embarrassing or socially inappropriate behavior
- ☐ Becomes verbally abusive When: _____
- ☐ Becomes agitated When: _____
- ☐ Becomes anxious When: _____
- ☐ Becomes combative When: _____
- ☐ Becomes stubborn or uncooperative When: _____
- ☐ Reports seeing or hearing things that are not there
- ☐ Denies or seems unaware that anything is wrong
- ☐ Appears depressed or withdrawn
- ☐ Cannot be left alone. Must be supervised
- ☐ Wanders *(Signal Centers is not appropriate for those individuals who are at risk for elopement)*
- ☐ Engages in behavior that is potentially dangerous to self or other

Explain: _____

_____

Please describe any other behaviors that may be helpful for our staff to know about.

_____
_____
_____

Participant – Interests *(Please check ALL that apply)*

	Current	Past
Sports	☐	☐
Listening to Music	☐	☐
Gardening	☐	☐
Drawing / Painting	☐	☐
Exercise	☐	☐
Cooking / Baking	☐	☐
Grandchildren	☐	☐
Traveling	☐	☐
Knitting /Sewing	☐	☐
Card Games	☐	☐
Singing	☐	☐
Looking at Magazines	☐	☐
Board Games	☐	☐
BINGO	☐	☐
Handyman	☐	☐
Dancing	☐	☐
Hunting / Fishing	☐	☐
Golf	☐	☐
Arts & Crafts	☐	☐
Needlepoint	☐	☐

Please list any other activities that client currently enjoys or did enjoy in the past

_____

Does the individual read? ☐ **No** ☐ **Yes – If so what?**

Does the individual write? ☐ **Yes** ☐ **No** ☐ **Name only**

Is the individual interested in technology? ☐ **Yes** ☐ **No**

What additional information will help us provide the best services?

_____

_____

_____

Name of person completing this application _____
(Please print)

Signature _____ ***Date*** _____