For Office Use Only:

Date Received: _____

Transportation:

_____

Jewish Home
ADULT DAY HEALTH CARE

Adult Day Health Care: Initial Screening Application

Please leave no blanks

Name: _____Preferred Name: _____

Address: _____

_____

Living Arrangements: _____ (Living alone, with family, within an agency)

Phone Number: _____ DOB: _____

Social Security Number: _____ Primary Language: _____

Medicaid Number: _____ Marital Status: ☐Single ☐ Married ☐ Widowed

MLTC/MMC Provider: _____ Gender Identity: _____

Contact Person/Care Manager: _____Phone #: _____

Email address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Address: _____

Email address: _____

Power of Attorney: ☐**Yes** ☐**No**

Primary Care Physician:

Facility: _____Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Seen in the last 12 months? ☐**Yes** ☐**No** DNR/MOLST: ☐**Yes** ☐**No** Legal Guardian: ☐**Yes** ☐**No**

Health Care Proxy: ☐**Yes** ☐**No**

Please attach these documents if applicable.

Program Interest: Day Program ☐ or Evening Program ☐

Attendance Days: Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Services Needed: Physical Therapy ☐ Occupational Therapy ☐ Speech ☐

Preferred Hospital: _____

Community Agencies/Services Involved (Name, Agency, Phone Number, Service provided) Please be specific:

_____

_____

_____

Diagnoses/Medical Concerns:

_____

_____

_____

Psychosocial Concerns:

_____

_____

Support Needs:

Diet: _____

Allergies to Food: ☐**Yes** ☐**No** If Yes: _____

Allergies to Medication: ☐**Yes** ☐**No** If Yes: _____

Any swallowing difficulties? ☐**Yes** ☐**No** Explain: _____

Check all that apply: Put details of care needs in the comment section below.

Mobility: ☐ Walker ☐ Wheelchair ☐ Cane ☐ No Device

Eating: ☐ None ☐ Food Cut ☐ Observed ☐ Hand Fed ☐ Altered Consistency: _____

Bladder: ☐ Continent ☐ Incontinent **Pads/Briefs:** ☐**Yes** ☐**No** If Yes, Size: _____

Toileting assist: ☐ None ☐ Some Assist ☐ Total Assist

Bowel: ☐ Continent ☐ Incontinent

Transferring Assistance Needed: Is a lift used, 1-person, 2-person assistance? Explain:

_____

Hearing: ☐ Within normal limits ☐ wears hearing aids ☐ Deaf ☐ Difficulty

Vision: ☐ Within functional limits ☐ wears corrective lenses ☐ partially impaired vision ☐ legally blind

Communication: ☐ Verbal ☐ Non-Verbal ☐ Difficult to understand ☐ Communication device

☐ Makes needs known ☐ can read/write

Adaptive Equipment Needed (AFO's, walker, brace, utensils, plates):

_____

_____

Covid Vaccination (This is required to attend program): ☐**Yes** ☐**No**

Please provide a copy of vaccination card

Will person require medications to be administered while at program? ☐Yes ☐No

If person will require medications to be given by a nurse while at program, be advised that all medications must come into program in a current labeled bottle. The label must have the person's name, medication name, dosage, frequency and route. If the person is self-medicating, they must be able to identify the medication, why they are taking it and when they should be taking the medication. All medications must be transported securely and safely.

Comments:

_____

_____

_____

If accepted into the program, it is required that an initial assessment and care plan is completed. This will occur every 6 months. Is this person able to report medical, social and psychological information independently?

☐**Yes** ☐**No**

If they are not able to report independently, who will assist in these assessment times upon admission and every 6 months while enrolled in program services?

_____

_____

Referral Sources: _____ Phone: _____

How did you hear about us? _____

Thank you for your interest! You can return your referral by fax to 585-341-2413 or by mailing to:

Jewish Home

Attn: Adult Day Health Care

2021 Winton Road South

Rochester, NY 14618