PROVIDENCE
Adult Day Health

6018 N. Astor
Spokane, WA 99208
Phone: 509-482-2475
Fax: 509-482-2490

CLIENT APPLICATION

Today's Date: ___________________

1. CLIENT INFORMATION

STA # ___________________

Name__________________________________ Preferred Name____________________

Address____

City________________________________ State_______________Zip Code_______________

Home Phone: ________________________ Cell Phone _________________________________

Birthdate ________________ Age____________ Social Security #____________________

Ethnicity: [ ] Caucasian [ ] African-American [ ] Native American [ ] Latino [ ] Mexican

[ ] Japanese [ ] Chinese [ ] Other: ______________________

Marital Status: (Please check all that apply)

[ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ] Single

Years Married: ____ Number of children: ____

Living Situation: (Please check all that apply)

[ ] Living alone [ ] With spouse [ ] With Adult Child

[ ] With Non-Relative (s) [ ] With partner [ ] With Other Relative (s)

[ ] With a hired caregiver [ ] Assisted Living Facility [ ] Adult Family Home

In-Home Contact/Caregiver: ______________________________ **Relationship** _________________

Phone: ___________________ **Cell Phone:** ___________________ **Fax:** ______________________

E-mail address: ____

CODE STATUS: **[ ] Full Code [ ] DNR**

ADVANCE DIRECTIVCE: **[ ] YES** **[ ] NO**
RECEIVED INFORMATION: **[ ] YES** **[ ] NO**

2. EMERGENCY INFORMATION

If the caregiver is unavailable please identify additional emergency contacts:

1. First Alternate Contact ________________________________Relationship___________________

   Address____

   Home Phone _______________ Work Phone__________________Cell Phone ______________

2. Second Alternate Contact ______________________________Relationship___________________

   Address____

   Home phone_______________ Work Phone__________________Cell Phone _______________

Military Information: [ ] Veteran Branch Served In: _________________ Yrs. Served: ________

3. FINANCIAL INFORMATION

Person to receive bill ______________________________________ Relationship ________________

Address (if different from caregiver above) ____

City ________________________ State ___________ Zip Code ________ Phone ________________

PLEASE PROVIDE DOCUMENTATION *(IF THE CLIENT HAS ANY OF THE FOLLOWING):*

- Does the Client have a Power of Attorney? [ ] Yes [ ] No If yes, who:
  Name ____________________________________ Phone ________________________________
  Address (if different from above) ____

- Does the client have a Durable Power of Attorney for Health Care? [ ] Yes [ ] No
  Name ____ Phone ___________________________
  Address____

- Does anyone have guardianship for the client? [ ] Yes [ ] No

Name____ Phone_______________________________

Address____

____
Client Name

4. CLIENT HEALTH INFORMATION

Current medical history/diagnosis ______________________________

____

____

Primary Health Care Provider: (Physician, Physician Assistant, or Nurse Practitioner)

Name ______________________ Phone ______________________

Address ______________________ City ______________ Zip ______

Additional Health Care Providers:

Name ______________________ Phone ______________________

Address ______________________ City ______________ Zip ______

Podiatrist ______________________ Phone ______________________

Hospital Preference ______________________ Last Admission ______________

Pharmacy ______________________

Special Health Conditions: (Please check all that apply)

[ ] Seizures [ ] Dizziness/Fainting [ ] Incontinence

[ ] Heart problems [ ] High/Low blood pressure [ ] Diabetes

[ ] Swallowing/Choking [ ] Heat/Cold sensitivity [ ] Other

[ ] Asthma/Breathing

Allergic reactions? *(Please check all that apply)*

[ ] Smoking [ ] Foods [ ] Medicines [ ] Animals [ ] Insects

[ ] Plants [ ] Other

Please explain ______________________________

____

____

____

____

Client Name

Recent Therapy: (*Last 6 months*)

[ ] PT [ ] OT [ ] Speech [ ] N/A

Provider: ____

Special equipment used: (Please check all that apply)

[ ] Hearing aid R/L [ ] Walker [ ] Hoyer lift
[ ] Glasses/contacts [ ] Prosthesis [ ] Cane
[ ] Dentures U/L [ ] Wheelchair [ ] Other
W/C vender___________________

Please explain what type of assistance is needed ____
____

Needs assistance with standing? [ ] Yes [ ] No
Needs assistance with walking? [ ] Yes [ ] No

Please explain ____
____
____

Has the client had a recent fall in the last 6 months? [ ] Yes [ ] No
Please describe circumstances or cause:____
____

Dietary restrictions: (Please check all that apply)

[ ] Low sodium [ ] Diabetic [ ] Needs assistance eating [ ] Other
Please explain ____
____
____

Toileting: (Please check all that apply)

[ ] Independent [ ] Needs assistance to toilet
[ ] Lacks bowel control [ ] Independent, use pads
[ ] Lacks bladder control [ ] Behavioral problems relating to toileting
[ ] Needs reminding to toilet

Please describe routine for toileting (i.e. how often, times of day, what type of assistance needed)
____
____
____

____
Client Name

MEDICATIONS

Please list ***ALL*** current medications, including oxygen, that are being administered at home, unless you have a medication administration record or a complete list of medications in another format, please provide a copy of those medicines.

Medication	Dose	Time	Reason

Will client be bringing medication to PADH? **[ ] Yes** **[ ] NO**
Self administered? **[ ] Yes** **[ ] NO**

Behaviors: (Please check all that apply)

[ ] Sociable
[ ] Cooperative
[ ] Talkative
[ ] Anxious
[ ] Helpful
[ ] Other
[ ] Agitative
[ ] Pacing
[ ] Verbally aggressive
[ ] Physically aggressive
[ ] Agitation increases in evening
[ ] Unable to recognize familiar people
[ ] Confusion
[ ] Wandering
[ ] Hallucinations
[ ] Unaware of surroundings
[ ] Socially withdrawn

What methods work best to handle behaviors? ____

____

What methods/approaches do **not** work? ____

____

____
Client Name

5. CLIENT SOCIAL INFORMATION

The following information will help to increase his or her abilities, self esteem and social contact.

Sensitive conversational topics ____
____

Are there any cultural and/or religious considerations that we should be aware of in order to provide quality care?
____
____

Club/memberships (past and present) ____
____
____

Interest/Hobbies past and present: (Please check all that apply)

[ ] Reading	[ ] Radio	[ ] Music	[ ] Woodworking
[ ] Walking	[ ] Sports	[ ] Lectures	[ ] Singing
[ ] Crafts	[ ] Sewing	[ ] Handiwork	[ ] Exercise
[ ] Gardening	[ ] Church	[ ] Concerts	[ ] Cooking
[ ] Travel	[ ] Games	[ ] Movie/TV	[ ] Dancing
[ ] Grooming	[ ] Pets	[ ] Collector	[ ] Prayer/Spiritual reading
[ ] Conversation	[ ] Plays instrument		

Additional comments ____
____
____

I UNDERSTAND THIS INFORMATION WILL BE GIVEN TO THE PROVIDENCE ADULT DAY HEALTH STAFF AND WILL BE KEPT ON FILE IN ITS OFFICE. THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANY OTHER PERSON OR ORGANIZATION WITHOUT MY WRITTEN PERMISSION.

Client Name ____
(Print Please)

Signature of Client ____ **Date** ____________________

Signature of Caregiver _____________________________________ **Date** ____________________

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AUTHORIZATION TO RELEASE AND RECEIVE INFORMATION

I,____(Participant Name), DOB___________________

authorize 'PROVIDENCE ADULT DAY HEALTH' to Release and Receive the following information:

Medical history, diagnosis, medications, treatments,
Care plan
____

To/FROM ____

____

RIGHTS OF THE PARTICIPANT:

- The information listed here above is to be released for only the stated purpose. Any other use is forbidden.
- I may inspect and receive a copy (nominal fees may be charged)
- This authorization is voluntary and I may refuse to sign the authorization form. I may not be refused treatment or payment if I refuse to sign this form.
- This authorization is valid until my relationship with the Providence Adult Day Health is discontinued. I understand that I may also revoke authorization at any time by contacting the Case Manager. The revocation must be in writing, dated and signed by the client or legal representative (DPOA).
- If I am providing authorization for marketing purposes, I understand that Providence Adult Day Health may receive payment from a business associate as a result of using or disclosing my information.
- I may receive a copy of this authorization if requested.
- Information disclosed as a result of this authorization may be re-disclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

I understand that I can revoke this authorization at any time with written notification. I am also aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

_______________________________________ ________________________
Signature of Participant/Responsible Party Date

For office use only

Dr/Clinic Fax #___________________ Preparers Initials ________

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Participant Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by asking the Case Manager for one.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Participant Name ____

Participant/Responsible Party Signature____

Date____

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Media Interview and Photography Authorization Form

Participant's Name: (print) ________________________________

Date of Birth: __________________

I authorize **Providence Adult Day Health (PADH)** to take photographs for:

☐ Medical Records and Identification badge
☐ Documenting program activities for group room bulletin boards and in-house displays
☐ Any publication or presentation. This may include, but not be limited to: publications, marketing presentations, web site, newspapers, and advertising.

***This authorization does not permit the disclosure of written medical records*

Select One

☐ My name **may** be revealed with the use of an interview and/or photograph(s).
☐ My name **may not** be revealed with the use of the interview and/or photograph(s).

This authorization is valid as long as I am a client of Providence Adult Day Health.

RIGHT OF THE PARTICIPANT

- The information listed here above is to be released for the stated purpose only. Any other use is forbidden.
- I may request to inspect and copy the information to be used pursuant to this authorization.
- This authorization is voluntary and I may refuse to sign this form. I will not be refused treatment if I refuse to sign this form.
- I understand that I may revoke authorization at any time. My revocation must be in writing. However, PADH is not responsible for actions already taken based upon this authorization.
- If I am providing authorization for marketing purposes, I understand that PADH may receive payment from a business associate as a result of using or disclosing my information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law.

______________________________________ ______________________

Signature of Participant or Personal Representative Date

______________________________________ ______________________

Printed name of Participant or Personal Representative Relationship to Participant

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EMAIL CORRESPONDENCE AGREEMENT

There is no requirement for Adult Day Health (ADH) staff and clients to use email to communicate with each other. However, ADH staff and clients may decide collectively to use email as one method of communication for the convenience, speed, and to help avoid "phone tag".

Risk of using email

Clients that want to use email to communicate with ADH staff about their personal health care may do so only after acknowledging the risks and signing this agreement. ADH staff will use reasonable means to protect the security and confidentiality of email information sent and received. Clients should understand that there are known and unknown risks that may affect the privacy of their personal health care information when using email to communicate. Those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without the client's or ADH staff knowledge or agreement.
- Email may be accidentally sent to the wrong address by both client and provider.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.

Conditions for the use of email

I agree not to use email for medical emergencies or to send time sensitive information. I understand and agree that it is my responsibility to follow up with ADH staff, if I have not received a response to my email within a reasonable time period.

I agree that the content of my email messages should state my question or concern briefly and clearly and include (1) the subject of the message in **the subject line should read CLIENT COMMUNICATION**, and (2) clear client identification **in the BODY** of the message. I agree it is my responsibility to inform ADH staff of any changes to my email address.

I also agree that, if I want to withdraw my consent to use email communications about my health care, it is my responsibility to inform ADH staff members by email from an authorized email address below or written communication only.

Understanding the use of email

I give my permission to ADH staff to send email messages that include my personal health care information and understand that any email messages may be included in my medical record.

By signing below I confirm that I have read and understand the risks involved in email communication, the types of appropriate email communication, and I give my permission to the provider listed above to respond to my emails at the address below or other address I may provide in writing in the future.

____

Client or Personal Representative Signature: Date:

(If signed by a personal representative of the client please complete the following.)

____

Personal Representative's Name (Please Print Clearly) Telephone Number:

Client's Name: ________________________________ Relationship to client: ___________________________

AUTHORIZED EMAIL ADDRESS 1: ____

AUTHORIZED EMAIL ADDRESS 2: ____

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Participant's Choice Regarding Cardio-Pulmonary Resuscitation

Date _________________

Client's Name _____________________________________

The above named participant and/or family member has received a copy of *The Self-Determination Act (Page 31 of the Participant Handbook).* The participant's wishes are stated below. If the participant chooses not to have CPR, the Providence Adult Day Health Nurse and the Case Manager will explain fully to the participant and/or family member what this entails. Persons involved in the discussion will sign below.

Self-Determination Act_____________ *(Staff initials)*

Initials	Date	
______	______	Received POLST Form
______	______	Agreed to Provide POLST Form
______	______	If CPR is not wished, I understand that CPR will be done *unless* the POLST Form is completed.

Persons Involved in Discussion:

__________________________ ________________________
Name Relationship

__________________________ ________________________
Name Relationship

__________________________ ________________________
Staff Signature

The Participant:

______ Wishes CPR

______ Does Not wish CPR (No Code)
(Form Attached & documentation in place)

Annual Review: *(Indicate Year)*

Wishes CPR _______ _______ _______ _______

No Code _______ _______ _______ _______

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Client Name ______________________________________ Social Security #_____________________

Address ______________________________________

____

Responsible party if different from above:

Name: ______________________________________ Social Security #_____________________

Address ______________________________________

____

ADMISSION CONSENT

I hereby authorize Providence Adult Day Health to provide day health care services to me as may be ordered by my physician including photographs that may be necessary for medical records. I have been given information about the care treatment plan and I agree to work cooperatively with the PADH staff towards the attainment of mutually agreed upon goals. I understand that my care plan may include nursing, rehabilitation and/or supportive counseling services.

PROMISE TO PAY

My daily costs of care and assessment fees are listed below. If I am privately funded, I am responsible for payment. I will receive monthly invoices from PADH and payment is due within 30- days. If payment is not received within 30 days, the center may refer my account to a collection agency.
If I have a third party agreement from a government program then that third party payer is responsible for payment and I assign PADH all monies from that government program for services rendered. PADH will be responsible for attaining authorization prior to me attending.

PARTICIPANT BILL OF RIGHTS & GRIEVANCE PROCEDURE

I have received a copy of the Providence Adult Day Health Participant Handbook and have read and/or had the Participant Bill of Rights and Grievance Procedures explained to me and I understand their content.

X____ _______________
Participant Signature or Responsible Party's Signature/Relationship to Participant Date
(*If other than participant signing – I affirm I have the Authority to sign for the participant)*

For Office Use Only

FUNDING INFORMATION

[ ] Private Day Health
[ ] Private Day Care – Level 1
[ ] Private Day Care – Level 2
[ ] Medicaid
[ ] Veterans Day Health
[ ] Veterans Day Care
[ ] Respite Care
[ ] SCSA
[ ] Other

One time Comprehensive Assessment Fee $____________

# of attendance days _________ M T W TH F Cost of Care $____________ per day

Request for Fluid Milk Substitution – Adult Care

Adult Participant's Name ____

Non-dairy milk substitution request:

If an adult participant cannot drink cow's milk due to medical or other special dietary needs but does not have a diagnosed medical disability, your provider may choose, but is not required, to provide a non-dairy milk substitute that is nutritionally equivalent to cow's milk, based on your request. At this time, only four brands of non-dairy milk substitutes available in Washington meet the definition of being nutritionally equivalent to cow's milk: 8th Continent Soymilk (Original and Vanilla), Pacific Ultra Soy (Original and Vanilla), Great Value Original Soymilk and Kirkland Organic Soymilk (Plain).

By completing the information below, the adult participant may be served one of these soy milks, provided by the adult care facility (if the adult care facility chooses), or provided by you.

Identify why the adult participant needs a non-dairy milk substitute: ______________________

____

______ I request the adult participant be served the adult care facility provided soy milk as described above for meals that require milk.

______ I will provide one of the soy milks described above for meals served to the adult participant that require milk.

Providers are required to serve a milk substitution that is nutritionally equivalent to cow's milk if the adult participant has a documented medical disability, diagnosed by a licensed physician, either a M.D. (Medical Doctor) or a D.O. (Doctor of Osteopathy). If the adult has been diagnosed with a medical disability that prevents the adult from consuming cow's milk or one of the approved soy milks listed above, submit a note from the physician identifying the following:

1) The adult participant's disability
2) The major life activities/bodily functions affected by the disability
3) A description of how the disability restricts the adult participant from drinking cow's milk and approved brands of soymilk
4) The prescribed food substitute

Cow's milk substitution request:

Providers may choose, but are not required, to serve lactose-reduced or lactose-free milk or organic milk to adults in their care. If the provider does not serve these milks, the household member/guardian may bring the substituted milk for the adult to consume while in care.

______I will provide 1% or nonfat lactose-reduced or lactose-free milk to be served in place of the milk served by the provider.

______I will provide 1% or nonfat organic milk to be served in place of the milk served by the provider.

Signature of Household Member/Guardian: ________________________ Date: ____________