SUCCESSFUL LIVING CENTER, INC.
"Bringing Generations Together"
1902 Bullard Street, Montgomery, AL 36106
Phone: 334-264-1790 /Fax 334-264 1792

REGISTRATION CHECKLIST

Participant's Full Name _____

Date of Birth: _____

Today's Date: _____

The following items must be completed and returned to Successful Living Center, Adult Day Care Center prior to enrollment:

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PARTICIPANT PERSONAL INFORMATION

Name: _____

Age: _____ Date of Birth: _____ Place of Birth:_____

Ethnic Origin (Irish, German etc.): _____Marital Status: _____

Address: _____

City/ State/ Zip: _____

Phone Number: _____

Level of Education: _____

Military History: _____

Employment History: _____

_____

Parents: _____ _____
Mother Father

INDICATE THOSE PERSONS ACTIVELY INVOLVED WITH THE PARTICIPANT

Siblings: _____

_____

Children: _____

_____

Grandchildren: _____

_____

Significant others: _____

How long has the participant lived where he or she is now? _____

Is a change of residence expected within the next six months? ☐ YES ☐ NO

Living situation:
- Alone ☐ YES ☐ NO
- With Spouse ☐ YES ☐ NO
- With Children ☐ YES ☐ NO (How many? _____)
- With Grandchildren ☐ YES ☐ NO (How many? _____)
- With other relatives ☐ YES ☐ NO (How Many? _____)
- With hired caregiver ☐ YES ☐ NO
- Other (includes congregate or institutional setting) ☐ YES ☐ NO

ACTIVITIES OF DAILY LIVING

E A T I N G

Special diet: _____

_____

_____

Needs:

No help	☐ YES	☐ NO
Remind	☐ YES	☐ NO
Supervise	☐ YES	☐ NO
Assist	☐ YES	☐ NO
Feed	☐ YES	☐ NO
Frequently resistant	☐ YES	☐ NO

Others: _____

Special Problems

Swallowing	☐ YES	☐ NO
Using utensils	☐ YES	☐ NO
Distraction	☐ YES	☐ NO
Frequently resistant	☐ YES	☐ NO

Others: _____

T O I L E T I N G

Needs:

No help	☐ YES	☐ NO
Remind	☐ YES	☐ NO
Supervise	☐ YES	☐ NO
Assist	☐ YES	☐ NO
Incontinent	☐ YES	☐ NO
Frequently resistant	☐ YES	☐ NO

How does participant signal need to use toilet? _____

_____

What is the participant's usual toileting routine/schedule time? _____

_____

If participant refuses to toilet? _____

_____

FUNCTIONAL CAPABILITIES (Check all items below)

☐ YES	☐ NO	Active, require no personal help of any kind; able to go up and down stairs easily
☐ YES	☐ NO	Active, but has difficulty climbing a=or descending stairs
☐ YES	☐ NO	Uses cane or crutch
☐ YES	☐ NO	Feeble or slow
☐ YES	☐ NO	Uses walker? If Yes, can get in and out unassisted?
☐ YES	☐ NO	Uses wheelchair? If Yes, can get in and out unassisted?
☐ YES	☐ NO	Requires grab bars in bathroom

Others (Describe): _____

R E C R E A T I O N

T V : _____
(Favorite programs)

Radio: _____
(Stations, News, Spiritual, Music – Classical, Gospel, Western, Old pops)

Reading: _____
(Bible, Newspaper, Magazines, Books)

Able to read ☐ YES ☐ NO

Prefer being read to ☐ YES ☐ NO

Hobbies and /or social activities did (does) the participant enjoy?

☐ YES	☐ NO	Listening to music
☐ YES	☐ NO	Singing
☐ YES	☐ NO	Playing musical instrument
☐ YES	☐ NO	Playing with or watching animals or pets
☐ YES	☐ NO	Playing with certain types of toys or games
☐ YES	☐ NO	Dancing or exercising
☐ YES	☐ NO	Knitting, needlework, sewing or other fine handiwork
☐ YES	☐ NO	Reading or looking at magazines
☐ YES	☐ NO	Drawing, painting or other art work
☐ YES	☐ NO	Gardening
☐ YES	☐ NO	Going for walk

Others (specify) _____

_____

BEHAVIOR ASSESMENT (Please check all that apply)

1.	Anxious in absence of primary caregivers	☐ YES	☐ NO
2.	Asking the same question over and over again	☐ YES	☐ NO
3.	Being constantly restless	☐ YES	☐ NO
4.	Being suspicious or accusative	☐ YES	☐ NO
5.	Destroying property	☐ YES	☐ NO
6.	Engaging in behavior that is potentially dangerous to other/ self	☐ YES	☐ NO
7.	Hiding things	☐ YES	☐ NO
8.	Losing or misplacing things	☐ YES	☐ NO
9.	Not recognizing familiar people	☐ YES	☐ NO
10.	Physically aggressive when upset	☐ YES	☐ NO
11.	Reliving situations from the past	☐ YES	☐ NO
12.	Seeing or hearing things that are not there (hallucinations or illusions)	☐ YES	☐ NO
13.	Unable to clean house	☐ YES	☐ NO
14.	Unable to concentrate on a task or activity	☐ YES	☐ NO
15.	Unable to do simple tasks which he/ she used to do (e.g. put away groceries, simple repairs)	☐ YES	☐ NO
16.	Unable to follow simple directions	☐ YES	☐ NO
17.	Unable to handle money (e.g., complete a transaction in a store; do not include being unable to manage finances)	☐ YES	☐ NO
18.	Unable to prepare meals	☐ YES	☐ NO
19.	Unable to stay alone	☐ YES	☐ NO
20.	Unable to use the phone	☐ YES	☐ NO
21.	Verbally abusive when upset	☐ YES	☐ NO
22.	Wandering or getting lost	☐ YES	☐ NO

INFORMATION ABOUT CAREGIVER

Caregiver/ Responsible Party Name: _____

Address: _____

City/State/ Zip: _____

Telephone No. _____/_____/_____
(Home) (Cell) (Work)

Car Make/ Model: _____ License Plate No. _____

Employer /Company Name:_____

Address: _____

City/ State/ Zip: _____

Job Title: _____

Spouse (if applicable): _____

Spouse Employer/Company Name: _____

Address: _____

City/State/Zip: _____

Work Phone No.: _____ Cell: _____

Does primary caregiver live with participant? ☐ YES ☐ NO

Length of time care giving _____ Relationship to participant: _____

Do you have help with care giving? ☐ YES ☐ NO How often: _____

By Whom: _____

Primary reason for using Day Care: _____

Referred to program by (record as many choices as applicable)

_____ Alzheimer's Association

_____ Church

_____ Doctor

_____ Family

_____ Friends

_____ Health Care Professional

_____ Media publicity

_____ Met with Executive Director

_____ Social Service Agency

_____ Support Group

_____ Other (please specify) _____

Successful Living Center, Inc. is a 501c3 non-profit organization and sometimes grant organizations require the income level of the individuals we serve. This information will be used only as data in making applications for grant funding. These funds would assist us in keeping our costs down and improving the quality of our programs.

Household Income: _____ (Month/Year) Number living in household: _____

POLICIES AND PROCEDURES AGREEMENT FORM

I have read the Policies and Procedures of Successful Living Center, Inc., Adult Day Care Center program and fully understand all information contained in the manual. The Director explained all of the information to me and I have been given a copy of the Policies and Procedures. I am enrolling:

_____

Participant Name

Monday	_____	Arriving at _____ a.m. / Departing at _____ p.m.
Tuesday	_____	Arriving at _____ a.m. / Departing at _____ p.m.
Wednesday	_____	Arriving at _____ a.m. / Departing at _____ p.m.
Thursday	_____	Arriving at _____ a.m. / Departing at _____ p.m.
Friday	_____	Arriving at _____ a.m. / Departing at _____ p.m.

I agree to pay for each week/month of care at the agreed-upon rate of _____ per day/month and understand this is due before the week/month of services. All overtime fees are due at the time of departure on the day fees are incurred. I agree to adhere to payment schedules and policies outlined in the caregiver's handbook.

I agree to pay fees Weekly _____

Monthly _____

CAREGIVER SIGNATURE: _____ DATE: _____

DIRECTOR SIGNATURE: _____

AUTHORIZATION FOR ADULT PICK UP
(Other than Primary Caregiver)

My parent (relative), _____ may be released to the following persons:

Individuals must show ID before the participant is released if they are other than primary caregivers.

(Friend/ Relative/ Guardian)

(1) _____ _____ _____ _____
Name | Relationship | Home Phone | Work/Cell Phone

(2) _____ _____ _____ _____
Name | Relationship | Home Phone | Work/Cell Phone

(Other persons Permitted to Pick Up)

(3) _____ _____ _____ _____
Name | Relationship | Home Phone | Work/Cell Phone

(4) _____ _____ _____ _____
Name | Relationship | Home Phone | Work/Cell Phone

(5) _____ _____ _____ _____
Name | Relationship | Home Phone | Work/Cell Phone

*(We will **NOT** allow your relative to leave our facility with anyone who is not listed above. You must notify Successful Living Center-Adult Day Care Center when someone other than the usual person will pick up your relative. This person will be asked to show a current driver's license or photo ID for identification)*

_____ _____

Caregiver **Date**

PHOTO / VIDEO RELEASE FORM

AUTHORIZATION TO USE PHOTOGRAPHS AND/ OR AUDIO-VISUAL

I, _____ hereby authorize Successful Living
Caregiver's Name

Center, Inc. to use, reproduce, and/ or publish photographs and/ or video that may pertain to

_____ including their image, likeness and/or
Participant's Name

voice. I understand that this material may be used in various publications, public affairs release, marketing materials, broadcast public service advertising (PSAs) or for other related community related awareness endeavors. These photos and/or videos may also appear on the Successful Living Center's or project sponsor's Internet Web Page or Facebook page. This authorization is continuous and may only be withdrawn by caregiver in writing. Consequently, Successful Living Center may publish materials, use participant's name, photograph, and videos that organization deems appropriate in order to promote/ publicize service opportunities and program participation. The day care center will sometimes be the subject of newspaper articles and television news stories in an effort to promote the benefits of the program to our community and other caregivers. Please be assured that participant will not be subjected to interviews or individual photographs by the media without permission of Center Director or her representative. Participants will not be depicted in any unflattering way in photographs or media to include television or internet web pages and social networking sites.

Date: _____ Signature: _____

Witness: _____

MEDICATION PERMISSION FORM

PARTICIPANT NAME: _____

Note: *Medication should be sent to day care in the current prescription bottle with participant's name and current date on it with dosage instructions. No medication will be accepted in any other container (pill holders, envelopes, etc.).*

MEDICATION	RX NO.	DOSAGE	TIME

I certify that the time and dosages of each above listed medication is correct. I agree to notify Director of Successful Living Center in case of any medication changes i.e. added, deleted or dosage adjustments. ***(Please submit copy of new prescription signed by physician for all dosage adjustment)***

_____ _____

Caregiver **Date**

EMERGENCY INFORMATION FORM

Participant Name: _____

Caregiver Name: _____

Home Phone No: _____

Cell Phone No: _____

Work Phone No: _____

Primary Physician: _____

Phone No: _____ Facsimile No: _____

Preferred Hospital: _____

ALTERNATE PERSON(S) to contact in case of emergency

(1) Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

(2) Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

I give Successful Living Center, Inc. permission to seek emergency medical treatment in case of sickness or accident. I understand and agree that I am fully responsible for any and all charges incurred.

_____ (Caregiver Signature) Date: _____

_____ (Print Name)

EMERGENCY MEDICAL TREATMENT FORM
(TO BE COMPLETED BY CAREGIVER)

Participant Name: _____ Date of Birth: _____

Address :_____ State/ Zip: _____

Caregiver Name: _____

Home Phone: _____ Cell: _____ Work: _____

MEDICAL INFORMATION *(Please list all of participant's health care providers and indicate with * as participant's Primary Physician)*

	N a m e	**Phone**
Cardiologist	_____	_____
Dentist	_____	_____
Eye	_____	_____
Geriatrician	_____	_____
Internal Medicine	_____	_____
Neurologist	_____	_____
Orthopedist	_____	_____
Podiatrist	_____	_____
Pulmonologist	_____	_____
Preferred Hospital	_____	_____

Health Insurance: _____ Group #: _____ Policy #:_____

Medicaid: ☐ Yes ☐ No Medicaid #: _____ Living Will: ☐ Yes ☐ No

List of medications: _____

_____

Dietary Restriction: _____

Drug / Food Allergies: _____

Please list any other information that emergency medical personnel/hospital may need to know (implants, past surgeries, etc.): _____

_____

I understand that first aid will be administered immediately in case of injury, that the program supervisor will determine the need for further medical treatment, and if required, that emergency services will be called for paramedic support. In addition, I do hereby authorize the representative of Successful Living Center, Inc. to have the participant named above transported, as emergency medical personnel deemed appropriate for purposes of rendering medical care. I understand that all costs of rendering such care are my responsibility. This form may accompany participants to medical facility to help healthcare personnel better evaluate my relatives' condition.

Caregiver's Signature _____ Director's Signature _____ Date _____

The person whose name appears below is an applicant for Adult Daycare Services at Successful Living Center, Inc. The purpose of the program is to help the person with dementia function at maximum capability and relieve the family member to work or have respite.

PHYSICIAN'S MEDICAL STATEMENT

Patient Name: _____ Date of Exam: _____

Length of time under your care: _____

Is there a diagnosis of Alzheimer Disease (or similar dementia)? ☐ Yes ☐ No

If Yes, when was the diagnosis made? _____

Is patient in early stages of disease? ☐ Yes ☐ No

Are there other medical problems? ☐ Yes ☐ No

If Yes, state the diagnosis and/ or impairment _____

_____

Please list all current medications patient is receiving:

Medication	Dosage	Frequency

Please provide additional medication page if needed.

Are there special treatments or considerations? ☐ Yes ☐ No

If Yes, please describe:

_____

_____

Are there dietary restrictions?

Are there restrictions on physical activity? ☐ Yes ☐ No

If Yes, please describe:

Allergies:

TB test result or current chest X-Ray and date: _____

(Please note that certification of a negative TB test or chest X-Ray within the past 3 months is required)

Has client been given Mini Mental Status Test or similar test? ☐ Yes ☐ No

If Yes, what were the results? _____

Do you have any additional comments and/ or recommendations?

Recommend for Adult Day Care at Successful Living Center? _____

Physician Name: _____ **(*please print*)**

Address: _____

City/ State/ Zip: _____ Phone & Fax No: _____

Physician Signature: _____ Date: _____

Physician's Medication Administration Permission Form

Patient Name: _____ Date of Birth: _____

Allergies: _____

PLEASE LIST EACH MEDICATION SEPARATELY

Medication: _____ Dosage: _____

Condition for which the medication is prescribed: _____

Select Medication Time(s) to be given: ☐ Morning snack ☐ Lunch ☐ Afternoon snack

☐ As needed for (what condition) _____

Medication: _____ Dosage: _____

Condition for which the medication is prescribed: _____

Select Medication Time(s) to be given: ☐ Morning snack ☐ Lunch ☐ Afternoon snack

☐ As needed for (what condition) _____

Medication: _____ Dosage: _____

Condition for which the medication is prescribed: _____

Select Medication Time(s) to be given: ☐ Morning snack ☐ Lunch ☐ Afternoon snack

☐ As needed for (what condition) _____

Physician's Name: _____ Tel.: _____

Physician's Signature: _____ Date: _____