

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: _____

Email: _____

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: _____

TOILETING

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): _____

RECREATION

TV : _____
(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?

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

Others (specify) _____

BEHAVIOR ASSESSMENT (Please check all that apply)

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

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)

(Print Name)

**EMERGENCY MEDICAL TREATMENT
 (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

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:

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: _____