

# 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	- With Spouse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	- With Children	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(How many? _____)
	- With Grandchildren	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(How many? _____)
	- With other relatives	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(How Many? _____)
	- With hired caregiver	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	- Other (includes congregate or institutional setting)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

## ACTIVITIES OF DAILY LIVING

### EATING

**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)**

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Active, require no personal help of any kind; able to go up and down stairs easily |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Active, but has difficulty climbing a=or descending stairs                         |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Uses cane or crutch  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Feeble or slow   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Uses walker? If Yes, can get in and out unassisted?                                |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Uses wheelchair? If Yes, can get in and out unassisted?                            |
| <input type="checkbox"/> YES | <input type="checkbox"/> 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 ASSESMENT (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<br>(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<br>(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;<br>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:

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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)

\_\_\_\_\_ (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)*

	<b>N a m e</b>	<b>Phone</b>
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:

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---

Allergies:

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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?

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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: \_\_\_\_\_