Valley Haven
Admission Agreement

I give consent for _____ to attend Valley Haven Adult Day Program.

ATTENDANCE
Scheduled days of attendance are: _____ for a total of _____ days per week.

TRANSPORTATION
I Do / Do Not request Valley Haven transportation at this time.

Scheduled days of transportation are: _____

Pick up / Drop off Address: _____

_____

I, _____, caregiver for _____ give Valley Haven implicit permission to release above named participant to the address whether or not a responsible person is there to receive them. I furthermore fully release and hold Valley Haven harmless, for any occurrence that could take place before said participant enters the van in the morning or after they have left it in the afternoon.

Signed, _____.

BILLING
I understand that Valley Haven's standard rate is $65/day. If the senior attends for less that the full 6 hours, than the hourly rate of $11/hour will apply. I understand that I will be billed on a monthly basis for services rendered the previous month. The billing is due and payable upon receipt of the monthly statement and is considered late after the 15th of each month. If payment is not received by the 15th of the month, a $20 late fee will apply.

CONSENT
I give / do not give Valley Haven permission to take photographs of participant for identification.
I give / do not give Valley Haven permission to release photographs for publicity purposes.
I give / do not give permission for participant to participate in Valley Haven field trips.

I have been given a copy of Commonly Asked Questions About Valley Haven and Commonly Asked Questions About Valley Haven Transportation and agree to the terms outlined therein. I have received a copy of the personal rights, and these rights have been explained to my satisfaction.

_____ _____ _____
Participant or Responsible Individual Relationship Date

_____ _____
Representative of Valley Haven Date

EMERGENCY CARD

Birth Date _____
Start Date _____

Client _____ Home Phone _____
(Please print last and first name)

Home Address_____
Street City
Zip

Family Contact_____ Home Phone _____ Cell Phone_____

Family Address_____

In case of an emergency, please contact the following local individuals:
First Contact_____ Relationship to client _____

Address_____

Home Phone _____ Cell Phone _____

Second Contact_____ Relationship to client _____

Address _____

Home Phone _____ Cell Phone _____

Client's Doctor _____Phone Number _____

Address _____

Client often wanders _____yes _____no

Client has a tendency to fall _____yes _____ no

Diagnosis _____
_____
Medications _____

Allergies _____

Special dietary needs _____
_____

_____ _____
Signature Date

We want to make Valley Haven Senior Day Program as safe and secure as possible for each of our clients.
Thank you for completing the above information.

MEDICAL INFORMATION RELEASE

I hereby authorize Valley Haven Adult Day Program to release information regarding _____ to any health care professional or emergency response personnel for the purpose of securing necessary medical or health related services.

I authorize any health care professional or emergency response personnel to release information to Valley Haven Adult Day Program when needed to assist Valley Haven in determining the type of care that is needed.

Consent:

As the representative or legal guardian, I hereby give consent to Valley Haven Adult Day Program to call on the local emergency response unit in the event that a condition arises which necessitates intervention to preserve the life or well being of my dependent.

_____ _____

Representative or Legal Guardian Date

Valley Haven
Transportation Release of Liability

I,_____, agree to indemnify and hold harmless Valley Haven, Inc, from any and all liability, loss, damage, costs or expenses which I may sustain, incur or be required to pay as a result of entering, exiting, or being transported on vehicles owned and/or operated by Valley Haven. This includes, but is not limited to the following: injury, death, property loss or damage while entering or exiting the vehicle or while being transported, or because of injury to another person or property of another person while being transported.

_____ _____

Signature Date

VALLEY HAVEN ADULT DAY PROGRAM
Client Information Sheet

_____ _____ _____
Participant's Full Name Birth date Age

_____ _____ _____
Address Phone Gender

CAREGIVER:

_____ _____
Caregiver Name Relationship (if any)

_____ _____ _____
Address Home phone Work phone

Are you responsible for the daily care of the participant? Always Sometimes Never
How long have you been responsible? _____
Do you work during the day? Yes / No Full-time / Part-time
Do you care for other family members? Yes / No
Would you like information about our free caregiver support group? Yes / No

_____ _____
Financially Responsible Party Relationship (if any)

_____ _____ _____
Address Phone

PARTICIPANT INFORMATION:

With whom does the senior live?_____ How long have they lived there?_____

Are they alone during the day? Yes / No Are they alone at night? Yes/ No

Does someone help with care? Yes/No Name of helper_____ Days/Hours_____

Does the participant use:
__Cane __Wheelchair __Glasses __Contact lenses __Dentures __Hearing Aid
__ Attends or Depends

Please rate the participant's level in:

Walking _____ Eating _____Using the restroom _____

Vision _____ Hearing_____ Memory _____

Confusion_____ Wandering_____ Depression _____

Aggression_____ Communication_____ Other _____

Describe any chronic confusions or misbeliefs_____

Best way you've handled the senior's confusion _____

How long has participant shown signs of confusion _____

_____ Children's names: _____
Spouse's Name Deceased? Y/N _____

_____ _____
Senior's previous occupation
Military Service? Yes/No War Veteran? Yes/No _____

Senior's last residence _____ How long did they live there?_____ With whom?_____

Religious Preference _____ Past interests _____

Current favorite activities_____

EMERGENCY INFORMATION:

Notify: (Please list in order of who to call first)

Name	Address	Day time phone	Cell Phone	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____	_____	_____
Physician's Name	Phone number	Date of last exam
_____	_____	_____
Medical Insurance	ID number	Group number

Medical History

__ Stroke __ Alzheimer's __ Heart problems __Diabetes
__ Arthritis __ Parkinson's __ High blood pressure __Dementia
__ Other _____ __ Dietary Restrictions _____

Please list all medications participant is currently taking:

Name	Mg.	Frequency	Taken for
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is participant allergic to any medications? Yes / No _____ _____

Will participant be taking medication while at Valley Haven? Yes / No

Has participant had a TB test in the last 12 months? Yes / No

Is there a Do Not Resussitate Order? Yes / No

Is there a Durable Power of Health Care? Yes / No Person listed _____

STATISTICAL INFORMATION:

Valley Haven relies extensively on donations, grants, and other forms of assistance. Some donors require that we supply anonymous, confidential information pertaining to the group we are serving in order for us to receive their reimbursement. Please assist us by disclosing the following information. Your participation is voluntary but very much appreciated.

How did you hear about Valley Haven? _____

Please check the racial/ethnic group of the participant:

___ White	___ American Indian	___ Asian
___ African American	___ Pacific Islander	___ Hispanic

_____	_____	_____
Participant or Responsible Individual	Relationship	Date

_____	_____
Representative of Valley Haven	Date

MEDICATION AUTHORIZATION FORM

Occasionally, a participant needs to take medication during the time at Valley Haven. We must have the following information about the medication on file in order to administer the medication properly and to comply with State Regulations. Please fill out a copy of this form for each medication (Which includes prescription, non prescription, vitamins, supplement or nutritional supplement such as Ensure) that needs to be taken at the senior's time during Valley Haven.

In order for Valley Haven to dispense medication, all medications must be in the original container with a correct label from the pharmacist (including the participants name) on it or in a bubble pack. MEDICATIONS IN ZIPLOCK BAGS WILL NOT BE ACCEPTED. For security reasons, any medications to be kept at Valley Haven must be given directly to the Van Driver, the Program Director or a Program Aide. (DO NOT TRANSPORT MEDICATIONS IN SENIORS PURSES OR POCKETS ETC.) If you have any Questions please don't hesitate to call Program Director at 733-9459 or Executive Director at 688-8052.

Participants Name_____

Name of Medication_____ Purpose_____

Description of pill (color, shape, size)_____

Dosage & time _____

(If PRN, attach signed Physicians written statement verifying patients ability to communicate his/her need for the medication)

If PRN, describe specific symptoms indicating need for the medication_____

If PRN, minimum number of hours between doses_____

If PRN, maximum number of doses allowed in 24-hou period_____

Special instructions, possible side effects_____
Physicians Name/Phone number_____

Physicians Signature_____Date_____