The Salvation Army Samaritan Center for Adult Care
228 West Hubert Avenue, Lancaster, Ohio 43130
Phone: 740-687-1921 Fax: 740-687-1928

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 Program Director 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.

Date _____

Participant_____
Printed Signature

Caregiver_____
Printed Signature

Staff Designee _____
Printed Signature

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Initial Assessment / Intake Form

Participant Name: _____
Last First MI

Living Arrangement: __Lives Alone __Lives w/ Spouse __Lives w/ child(ren) __W/ Others

Address:_____City:_____

State: _____ Zip Code:_____ School District:_____

County:_____ Phone Number: (_____)_____

Sex: Male / Female Date of Birth:_____ Place of Birth _____

Marital Status: Single Married (when? _____) Spouse Name:_____

Widowed (when? _____) Divorced (when?_____)

Social Security Number:_____ Medicare #_____

Medicaid # _____ VA # _____

Other Insurance: _____ Participant's Monthly Income_____

Emergency Contact Information:

1. Name:_____ Relationship _____

Address:_____City: _____

State:_____ Zip Code:_____ EMAIL:_____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

2. Name:_____Relationship_____

Address:_____City: _____

State:_____ Zip Code:_____ EMAIL:_____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Participant Name: _____

Others who the participant may be released into the care of / information shared with:

Name_____ relationship _____ phone _____

Name_____ relationship _____ phone _____

Name_____ relationship _____ phone _____

Monthly Billing Statement for Services should be sent to: ***(if other than primary contact)***

Name:_____Relationship_____

Address:_____City: _____

State:_____ Zip Code:_____ EMAIL:_____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Participant's ability to sign for services: ***(check all that apply)***

_____ can sign own signature
_____ uses initials
_____ makes an "x" mark
_____ unable to sign
_____ family/ caregiver signs for them
_____other_____

Reason(s) for Adult Day Services: ***(check all that apply)***

_____ Family/Caregiver Work
_____ Family/Caregiver in School
_____ Family/Caregiver Respite/Relief
_____ Family/Caregiver Health & Well-being
_____ Socialization/Activities
_____ Protection and Supervision
_____ Improve Participant's Mental Health
_____ Alternative to Institutionalization

Primary Physician: _____ Date last seen? _____

Address:_____

City: _____ State:_____ Zip Code:_____

Office Phone # _____ Fax # _____

Participant Name: _____

Other Physician: _____ Date last seen?_____

Address: _____

City: _____ State: _____ Zip Code:_____

Office Phone # _____ Fax #_____

Allergies:

Known Drug Allergies: _____

_____

Known Food Allergies: _____

_____

Known Environmental Allergies: _____

_____

Has the participant ever experienced any of the following health problems:
(check all that apply)

___Alzheimer's Disease
___Anemia
___Bowel Problems
___Cancer
(type_____)
___CHF
___Choking
___Chronic Lung Disease
___Depression
___Diabetes (type _____)
___Dizziness
___Fractures
___Headaches
___Head Injury
___Heart Attack
___Heart Disease
___Hernia
(location_____)
___High Blood Pressure
___Inability to Speak
___Joint Pain / Arthritis
___Kidney Problems
___Loss of Balance
___Memory Problems
___Multiple Sclerosis
___Osteoporosis
___Ostomy
(type_____)
(location_____)
___Paralysis
___Parkinson's Disease
___Pneumonia
___Seizure
___Skin Problems
___Stomach Problems
___Stroke
___Thyroid Problems
___Urinary Infections

Primary Medical Diagnosis: _____

Other Health / Mental Health / Medical Concerns: _____

_____

Participant Name: _____

Surgeries/ Procedures: _____

_____

Catheter? Yes / No -type _____

Pacemaker? Yes / No Defibrillator? Yes / No

Prosthetic? Yes/ No -type_____ Needs help with prosthetic? _____

Dentures? Yes / No ___ upper ___ lower Partials? Yes / No ___ upper ___ lower

Hearing Loss? Yes / No Hearing Aid? ___ right ___ left ___ both

Vision Deficits? Yes / No Glasses /Corrective Lens? Yes / No reading only?_____

Oxygen Use? Yes / No ___Night time only? L/M? ___2% ___3% ___4% ____Other _____

Medications: _____

_____

_____

Bladder and Bowel Control

Incontinence / Bladder:

___Never Incontinent	___On Occasion	___Often, but not Daily
___Daily with some control	___No Control	___Unknown

Incontinence / Bowel:

___Never Incontinent	___On Occasion	___Often, but not Daily
___Daily with some control	___No Control	___Unknown

Does the participant have irregular bowel movement patterns? __diarrhea? __constipation?

Does the participant use incontinent products? Yes / No (type: __ pad __ pull-on __ tabs)

Is Participant able to tell you when they need to use the restroom? Yes / No

Does the Participant need reminders to use the restroom? Yes / No

Does the Participant need cues /direction and stand-by help while in the restroom? Yes / No

Does the Participant need physical help while in the restroom? Yes / No

Participant Name: _____

Please put a mark in the box that indicates the frequency of the behavior:

Behavior Evaluation	Never	Not in the past Week	1-2 times in the past week	3-6 times in the past week	Daily or more often
Verbal					
1. Repetitive questions					
2. Mixes past and present					
3. Talks aggressively					
4. Talks constantly					
5. Talks little or not at all					
6. Dwells on the past					
Actions					
7. Loses, misplaces or hides things					
8. Engages in dangerous activities					
9. Easily tearful					
10. Problems eating (volume/utensils					
11. Wanders or gets lost					
12. Does not recognize familiar people					
13. Forgets what day it is					
14. Unable to occupy self					
15. Follows you around					
16. Falls/ Fall Risk					
Psychological					
17. Suspicious or accusative					
18. Inactive					
19. Appears sad or depressed					
20. Becomes Angry					
21. Sees/hears things that are not there					
22. Relives situations in the past.					
Agitation					
23. Restless or agitated					
24. Uncooperative					
25. Strikes Out					
26. Wakes you up at night					
27. Interrupts you when you are busy					

Mobility

___ independent ___ cane (straight/quad) ___walker (___wheeled ___ w/seat) ___ wheelchair

Walking Distance: ___unlimited ___short distance ___very limited ___ not at all

_____ Needs close supervision while walking ? _____ Needs physical help to get up?

_____ Walking program while at Samaritan Center? Gait Belt? Yes / No

Participant Name: _____

Diet

_____Regular ___Diabetic ___Cardiac ___Renal ___Other _____

Consistency: _____Regular? _____Mechanically Altered *(Cut-Up vs. Ground)*? _____Pureed?

Thickened Liquids? _____no _____yes How thick? ___ nectar ___ honey ___ pudding

Food Preferences- Favorites: _____

Dislikes: _____

Breakfast:

_____Coffee? _____ Hot Tea? _____ Iced Tea? *With* _____*Cream?*____ *Sugar?*____ *Sweetener?*

_____Toast*?* _____*With Butter?* _____ *Jelly?(grape/strawberry)* _____*Peanut Butter?*

Lunch:

_____Coffee? _____ Hot Tea?_____ Iced Tea? With _____Cream?_____ Sugar?_____ Sweetener?

If given a choice, which do you prefer? (mark only one) ___Chicken ___Fish ___Salmon

Milk? (mark only one) _____none _____Chocolate _____2% _____Skim

Liver and Onions? _____likes _____ does not like, order alternate

Cycle of Daily Living

Participants Primary Language? _____

If different as a child, what language?_____

Religious Preference: _____

Church Name: _____ Address_____

Smoking Habits? ___none ___history of ___ daily use ___ other (details)_____

Alcohol Use? ___none ___history of ___ daily use ___ other (details)_____

Participant Name: _____

Sleeping Routine: Time awake _____ Time to bed_____

Does Participant wear bed clothes most of the day? _____ yes _____ no

Does Participant naps regularly during the day (at least one hour)? _____ yes _____ no

Does Participant have a fixed daily routine?_____ yes _____ no

Does Participant spend time alone? _____ yes _____ no

Does Participant go out and about at least one time a week? _____ yes _____ no

Does Participant have daily animal companionship / presence? _____ yes _____ no

Describe _____

Does Participant have animal allergies? _____ yes _____ no Describe _____

<u>School and Work…</u>

Education History:

Highest Grade Completed: _____ _____HS Grad? _____GED?
_____ Attended Technical/Vocational/Trade School? _____ Attended College?
Highest Degree Completed: _____

Work History: _____

Military History: yes / no Branch_____ #of years_____ War? _____

<u>Family …</u>

Number of Siblings: _____

Name of Siblings: _____

_____

Number of Children _____

Children Names: _____

_____

Describe Participants' Support Systems: _____

_____

Participant Name: _____

Favorites: Color_____ Season_____ Place_____

Check activities that are of interest:

_____Jig-saw Puzzles	_____Crossword Puzzles	_____Word search
_____Music (type _____)	_____Church/Religion	_____TV
_____Games (type _____)	_____Cards (type_____)	_____ Movies
_____ Reading	_____Exercise	_____Gardening
_____Cooking	_____Crafts	_____ Woodworking

Hobbies, Clubs, Interests, Skills: _____

_____

Special Memories: _____

_____

Participant's Strengths:

_____

_____

_____

Participant's Needs, Problems or Difficulties:

_____

_____

_____

Specific Goals/Objectives:

_____

_____

_____

_____

_____

Participant Name: _____

Activities of Daily Living

During the past 7 days, and considering all episodes, rate the participant's ability to perform:

Bathing (include shower, full tub or sponge Bath, exclude washing back or hair)

___Independent (0)
___Supervision (1)
___Requires Help Sometimes (2)
___Mostly Dependent (3)
___Totally Dependent (4)
___Activity did not occur (5)

Transfer (move from chair to chair):

___Independent (0)
___Supervision (1)
___Minimal Help Required (2)
___Mostly Dependent (3)
___Totally Dependent (4)
___Activity did not occur (5)

Dressing:

___Independent (0)
___Supervision (1)
___Limited Assistance (2)
___Extensive Assistance (3)
___Totally Dependent (4)
___Activity did not occur (5)

Eating

___Independent (0)
___Supervision (1)
___Sometimes Dependent (2)
___Mostly Dependent (3)
___Totally Dependent (4)
___Unknown (5)

Toilet Use:

___Independent (0)
___Supervision (1)
___Sometimes Dependent (2)
___Mostly Dependent (3)
___Totally Dependent (4)
___Activity did not occur (5)

Walking In Home:

___Independent (0)
___Supervision (1)
___Limited Assistance (2)
___Extensive Assistance (3)
___Totally Dependent (4)
___Activity did not occur (5)

Participant Name: _____

Instrumental Activities of Daily Living

During the past 7 days, and considering all episodes, rate the participant's ability to perform:

Meal Preparation:

___Independent (0)
___Sometimes Dependent (1)
___Mostly Dependent (2)
___Totally Dependent (3)
___Activity does not occur (4)

Medication Management:

___Independent (0)
___Needs Reminders (1)
___Somewhat Dependent (2)
___Totally Dependent (3)
___Activity does not occur (4)

Money Management:

___Independent (0)
___Needs Help Sometimes (1)
___Needs Help Most of the Time (2)
___Completely Dependent (3)
___Activity does not occur (4)

Heavy Housework:

___Independent (0)
___Needs Help Sometimes (1)
___Needs Help Most of the Time (2)
___Unable to perform tasks (3)
___Activity does not occur (4)

Light Housekeeping:

___Independent (0)
___Needs Help Sometimes (1)
___Needs Help Most of the Time (2)
___Unable to perform tasks (3)
___Activity does not occur (4)

Shopping:

___Independent (0)
___Sometimes Dependent (1)
___Mostly Dependant (2)
___Totally Dependent (3)
___Activity does not occur (4)

Transportation:

___Independent (0)
___Sometimes Dependent (1)
___Mostly Dependent (2)
___Totally Dependent (3)
___Activity does not occur (4)

Rank ability to use telephone:

___Independent (0)
___Able to perform but needs verbal assistance (1)
___Can perform with some human help (2)
___Can perform with a lot of human help (3)
___Cannot perform function at all without human help (4)
___Paramedical services needed (5)

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Initial Assessment / Intake Verification Form:

Date _____

Participant: _____
Printed Signature

Caregiver: _____
Printed Signature

Other: _____
Printed Signature

Staff Designee: _____
Printed Signature

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Home Alone Release

Transportation is available to our participants. Sometimes a participant may be left at home by themselves per family requests. Please indicate below if you authorize The Salvation Army Samaritan Center for Adult Care to leave the participant at their residence or designated drop-off location unattended. The Salvation Army Samaritan Center for Adult Care wants all of our participants to be safe at all times. However, The Salvation Army Samaritan Center for Adult Care cannot be liable for participants left home alone after we transport home.

_____ Participant ***may*** be left at home alone.

_____Participant ***may not*** be left at home alone.

If no one is home to receive a participant, the participant may be brought back to the Center until a family member can come after them.

Date _____

Participant Name: _____

Caregiver: _____
Printed Signature

Staff Designee: _____
Printed Signature

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Authorization for Release of Information

Participant Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

I hereby authorize _____
(Physician's Name / Medical or Mental Health Entity)

to exchange information regarding my diagnosis, medication, medical/mental health history and treatment plan. This information is necessary for admission and plan of care at The Salvation Army Samaritan Center for Adult Care.

The extent and nature of information to be disclosed is relating to request for Adult Day Services, problems and needs presented as well as any proposed client treatment plans. The purpose or need for the disclosure is to obtain records and recommendations for the client's care and program planning.

This authorization will automatically expire when the client is no longer enrolled in the Samaritan Center for Adult Care Program unless an earlier date, event or condition is specified (_____). The participant or caregiver/responsible party may revoke the authorization prior to the above event/date via a written, dated request. Upon receipt of such revocation notice, no further information will be released. The information released hereby is not to be re-released to any person or agency.

Date _____

Participant / Caregiver _____
Printed Signature

Staff Designee _____
Printed Signature

I hereby revoke my consent for release of the above information:

_____
Printed *Signature* *Date*

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Medications Given at the Samaritan Center

Please keep in mind that our nursing staff can only administer medications (prescribed and over-the-counter) if the medication is brought in their original (or pharmacy duplicate) container that is appropriately labeled.

In addition, to increase the safety and protection of your loved one, **a MEDICATION ADMINISTRATION AUTHORIZATION FORM should be completed and signed by the family / caregiver for each medication that is given at The Salvation Army Samaritan Center. Your signature and instructions are needed on the forms.** A new medication administration form should be completed with any addition or change in medication – this includes if the medication has been stopped.

We also appreciate health updates as changes occur. As you may recall, this is part of the caregiver's agreement that was signed upon admission to our program. Please feel free to contact the nursing staff with any questions or concerns.

Blessings,

BreAnne Shick, RN
Program Nurse

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The Salvation Army Samaritan Center for Adult Care
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Participant Name _____

Physician's Name _____ Physician's Office Phone _____

Name of Drug _____

Dosage _____ Time(s) to be given at The Samaritan Center _____

Drug is to be given: 1). _____ by mouth 2). _____ by inhaler 3). _____ other _____

Start Date _____ Discontinue After _____

I request and give permission to The Salvation Army Samaritan Center Nursing Personnel to assist in the administration on the listed medication to the participant named above. I understand that the administration of this medication will not start until this form is signed by the family member / caregiver and the program nurse. I understand that the medication brought to The Samaritan Center must be in the container in which it was dispensed by a physician or pharmacist. Over-the-counter drugs must be in the original container.

Signature of Family Member / Caregiver _____ Date _____

Signature of Program Nurse _____ Date _____

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Podiatry Services

The Salvation Army Samaritan Center works with Michael J. Ritchey, D.P.M to provide podiatry services. Dr. Ritchey comes to the facility every three months.

Please indicate below if you would like to receive more information about podiatry services offered at The Samaritan Center for Adult Care.

Date_____

_____ Yes, I would like more information about Podiatry Services offered at The Samaritan Center.

_____ No, not at this time.

Participant _____
Printed Signature

Caregiver _____
Printed Signature

Staff Designee _____
Printed Signature

Follow-up Notes:

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List of Needed Items

Thank you for your interest and application. Please bring the following with you to complete the admission process:

_____Medication List (name of medication, dosage, and reason for medication)

_____ Power of Attorney Papers

_____ Durable Power of Attorney Papers

_____ Living Will Papers

_____ Do Not Resuscitate Order Papers

_____ Medicare / Medicaid / Insurance Cards

Other items you may need to bring:

_____ A change of clothes (You can leave a set at the Center)

_____ Personal Care Products