PROVIDENCE
Adult Day Health

CLIENT APPLICATION

6018 N. Astor
Spokane, WA 99208
Phone: 509.482.2475
Fax: 509.482.2490

Today's Date: _____

1. CLIENT INFORMATION

STA # _____

Name_____ Preferred Name_____

Address_____

City_____ State_____Zip Code_____

Home Phone: _____ Cell Phone _____

Birthdate _____ Age_____ Social Security #_____

Gender: ☐ Male ☐ Female **Identifies as:** ☐ Male ☐ Female

Race: ☐ Caucasian ☐ Black/African-American ☐ American Indian/Native Alaskan

☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Not Latino

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single
(Please check all that apply)

Years Married: _____ Number of children: _____

Living Situation: ☐ Living alone ☐ With Spouse ☐ With Adult Child ☐ With Parent(s)

(Please check all that apply) ☐ With Non-Relative (s) ☐ With Partner ☐ With Other Relative (s)

☐ With Hired Caregiver ☐ Assisted Living Facility ☐ AFH

Military Information: ☐ Veteran Branch Served In: _____ Yrs. Served: _____

In-Home Contact/Caregiver: _____ Relationship _____

Phone: _____ Cell Phone: _____ Fax: _____

E-mail address: _____

FOR OFFICE USE ONLY **CODE STATUS:** **[☐] Full Code** **[☐] DNR**

ADVANCE DIRECTIVCE: [☐] YES [☐] NO
RECEIVED INFORMATION: [☐] YES [☐] NO

2. EMERGENCY INFORMATION

If the caregiver is unavailable please identify additional emergency contacts:

1. First Alternate Contact _____ Relationship _____

   Address _____

   Home Phone _____ Work Phone _____ Cell Phone _____

2. Second Alternate Contact _____ Relationship _____

   Address _____

   Home phone _____ Work Phone _____ Cell Phone _____

3. FINANCIAL INFORMATION

Person to receive bill _____ Relationship _____

Address (if different from caregiver above) _____

City _____ State _____ Zip Code _____ Phone _____

PLEASE PROVIDE DOCUMENTATION *(IF THE CLIENT HAS ANY OF THE FOLLOWING):*

- Does the Client have a Power of Attorney? ☐ Yes ☐ No If yes, who:

  Name _____ Phone _____

  Address (if different from above) _____

- Does the client have a Durable Power of Attorney for Health Care? ☐ Yes ☐ No

  Name _____ Phone _____

  Address _____

- Does anyone have guardianship for the client? ☐ Yes ☐ No

Name _____ Phone _____

Address _____

_____

Client Name

4. CLIENT HEALTH INFORMATION

Current medical history/diagnosis _____

_____

_____

Primary Health Care Provider: (Physician, Physician Assistant, or Nurse Practitioner)

Name _____ Phone _____

Address _____ City _____ Zip _____

Additional Health Care Providers:

Name _____ Phone _____

Address _____ City _____ Zip _____

Podiatrist _____ Phone _____

Hospital Preference _____Last Admission _____

Pharmacy _____

Special Health Conditions: (Please check all that apply)

- ☐ Seizures
- ☐ Dizziness/Fainting
- ☐ Incontinence
- ☐ Heart problems
- ☐ High/Low blood pressure
- ☐ Diabetes
- ☐ Swallowing/Choking
- ☐ Heat/Cold sensitivity
- ☐ Asthma/Breathing
- ☐ Other _____

Allergic reactions? *(Please check all that apply)*

- ☐ Smoking
- ☐ Foods
- ☐ Medicines
- ☐ Animals
- ☐ Insects
- ☐ Plants
- ☐ Other

Please explain _____

_____

_____

_____
Client Name

Recent Therapy: (*Last 6 months*)

[ ] PT [ ] OT [ ] Speech [ ] N/A

Provider: _____

Special equipment used: (Please check all that apply)

[ ] Hearing aid R/L [ ] Walker [ ] Hoyer lift [ ] Prosthesis
[ ] Glasses/contacts [ ] Cane [ ] Dentures U/L [ ] Wheelchair
[ ] Other _____ W/C vender_____

Please explain what type of assistance is needed _____

_____

Needs assistance with standing? [ ] Yes [ ] No
Needs assistance with walking? [ ] Yes [ ] No

Please explain _____

_____

_____

Has the client had a fall in the last 6 months? [ ] Yes [ ] No
Please describe circumstances or cause:_____

_____

Dietary restrictions: [ ] Low sodium [ ] Diabetic [ ] Needs assistance eating [ ] Other
(Please check all that apply) **Please explain** _____

_____

_____

Toileting: [ ] Independent [ ] Needs assistance [ ] Needs reminding to toilet
(Please check all that apply) [ ] Lacks bowel control [ ] Independent, use pads
[ ] Lacks bladder control [ ] Behavioral problems relating to toileting

Please describe routine for toileting (i.e. how often, times of day, what type of assistance needed)

_____

_____

_____

_____
Client Name

MEDICATIONS

Please list ***ALL*** current medications, including oxygen, that are being administered at home, unless you have a medication administration record or a complete list of medications in another format, please provide a copy of those medicines.

Medication	Dose	Time	Reason

Will client be bringing medication to PADH? ☐ Yes ☐ NO
Self administered? ☐ Yes ☐ NO

5. CLIENT SOCIAL INFORMATION

The following information will help to increase his or her abilities, self-esteem and social contact.

Sensitive conversational topics _____

_____

Are there any cultural and/or religious considerations that we should be aware of in order to provide quality care?

_____

_____

Club/memberships (past and present) _____

_____

_____

_____
Client Name

Behaviors: *(Please check all that apply)*

☐ Sociable	☐ Agitative	☐ Confusion
☐ Cooperative	☐ Pacing	☐ Wandering
☐ Talkative	☐ Verbally aggressive	☐ Hallucinations
☐ Anxious	☐ Physically aggressive	☐ Unaware of surroundings
☐ Helpful	☐ Agitation increases in evening	☐ Socially withdrawn
☐ Other	☐ Unable to recognize familiar people	

What methods work best to handle behaviors? _____

_____

What methods/approaches do **not** work? _____

_____

Activities/Interest/Hobbies past and present:
(Please check all that apply)

☐ Crafts	☐ Gardening	☐ Music	
☐ Painting	☐ Reading	☐ Cooking	[

Additional comments _____

_____

_____

I UNDERSTAND THIS INFORMATION WILL BE GIVEN TO THE PROVIDENCE ADULT DAY HEALTH STAFF AND WILL BE KEPT ON FILE IN ITS OFFICE. THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANY OTHER PERSON OR ORGANIZATION WITHOUT MY WRITTEN PERMISSION.

Client Name _____
(Print Please)

Signature of Client _____ **Date** _____

Signature of Caregiver _____ **Date** _____

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AUTHORIZATION TO RELEASE AND RECEIVE INFORMATION

I,_____(Participant Name), DOB_____

authorize 'PROVIDENCE ADULT DAY HEALTH' to Release and Receive the following information:

Medical history, diagnosis, medications, treatments, Care plan

_____

To/FROM _____

_____

RIGHTS OF THE PARTICIPANT:

- The information listed here above is to be released for only the stated purpose. Any other use is forbidden.
- I may inspect and receive a copy (nominal fees may be charged)
- This authorization is voluntary and I may refuse to sign the authorization form. I may not be refused treatment or payment if I refuse to sign this form.
- This authorization is valid until my relationship with the Providence Adult Day Health is discontinued. I understand that I may also revoke authorization at any time by contacting the Case Manager. The revocation must be in writing, dated and signed by the client or legal representative (DPOA).
- If I am providing authorization for marketing purposes, I understand that Providence Adult Day Health may receive payment from a business associate as a result of using or disclosing my information.
- I may receive a copy of this authorization if requested.
- Information disclosed as a result of this authorization may be re-disclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

I understand that I can revoke this authorization at any time with written notification. I am also aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

_____ _____

Signature of Participant/Responsible Party Date

For office use only

Dr/Clinic Fax #_____ Preparers Initials _____

PROVIDENCE
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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 Case Manager 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.

Participant Name _____

Participant/Responsible Party Signature_____

Date_____

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Media Interview and Photography Authorization Form

Participant's Name: (print) _____

Date of Birth: _____

I authorize **Providence Adult Day Health (PADH)** to take photographs for:

☐ Medical Records and Identification badge
☐ Documenting program activities for group room bulletin boards and in-house displays
☐ Any publication or presentation. This may include, but not be limited to: publications, marketing presentations, web site, newspapers, and advertising.

***This authorization does not permit the disclosure of written medical records*

Select One

☐ My name **may** be revealed with the use of an interview and/or photograph(s).
☐ My name **may not** be revealed with the use of the interview and/or photograph(s).

This authorization is valid as long as I am a client of Providence Adult Day Health.

RIGHT OF THE PARTICIPANT

- The information listed here above is to be released for the stated purpose only. Any other use is forbidden.
- I may request to inspect and copy the information to be used pursuant to this authorization.
- This authorization is voluntary and I may refuse to sign this form. I will not be refused treatment if I refuse to sign this form.
- I understand that I may revoke authorization at any time. My revocation must be in writing. However, PADH is not responsible for actions already taken based upon this authorization.
- If I am providing authorization for marketing purposes, I understand that PADH may receive payment from a business associate as a result of using or disclosing my information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law.

_____ _____
Signature of Participant or Personal Representative Date

_____ _____
Printed name of Participant or Personal Representative Relationship to Participant

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EMAIL CORRESPONDENCE AGREEMENT

There is no requirement for Adult Day Health (ADH) staff and clients to use email to communicate with each other. However, ADH staff and clients may decide collectively to use email as one method of communication for the convenience, speed, and to help avoid "phone tag".

Risk of using email

Clients that want to use email to communicate with ADH staff about their personal health care may do so only after acknowledging the risks and signing this agreement. ADH staff will use reasonable means to protect the security and confidentiality of email information sent and received. Clients should understand that there are known and unknown risks that may affect the privacy of their personal health care information when using email to communicate. Those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without the client's or ADH staff knowledge or agreement.
- Email may be accidentally sent to the wrong address by both client and provider.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.

Conditions for the use of email

I agree not to use email for medical emergencies or to send time sensitive information. I understand and agree that it is my responsibility to follow up with ADH staff, if I have not received a response to my email within a reasonable time period.

I agree that the content of my email messages should state my question or concern briefly and clearly and include (1) the subject of the message in **the subject line should read CLIENT COMMUNICATION**, and (2) clear client identification **in the BODY** of the message. I agree it is my responsibility to inform ADH staff of any changes to my email address.

I also agree that, if I want to withdraw my consent to use email communications about my healthcare, it is my responsibility to inform ADH staff members by email from an authorized email address below or written communication only.

Understanding the use of email

I give my permission to ADH staff to send email messages that include my personal health care information and understand that any email messages may be included in my medical record.

By signing below I confirm that I have read and understand the risks involved in email communication, the types of appropriate email communication, and I give my permission to the provider listed above to respond to my emails at the address below or other address I may provide in writing in the future.

Client or Personal Representative Signature: Date:

(If signed by a personal representative of the client please complete the following.)

Personal Representative's Name (Please Print Clearly) Telephone Number:

Client's Name: _____ Relationship to client: _____

AUTHORIZED EMAIL ADDRESS 1: _____

AUTHORIZED EMAIL ADDRESS 2: _____

PROVIDENCE
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Participant's Choice Regarding
Cardio-Pulmonary Resuscitation

Name:_____ Date:_____

We, at Providence Adult Day Health (PADH) want to ensure that the wishes of each participant are respected. Each participant can choose to have or not have Cardio-Pulmonary Resuscitation (CPR). By law, if your wish is not to have CPR, a document called the ***Physician Order for Live-Sustaining Treatment*** (POLST) form needs to be provided to PADH. This form needs to be signed by the participant or the guardian with health care authority or health care agent **AND** a physician.

At PADH, we can provide you with a POLST form if you do not have one. This form needs to be completed and signed by the physician. Please return a copy of your signed POLST form to PADH as soon as possible.

Please initial and date after reading the following statement:

I/We understand that CPR will be done, ***unless*** a **POLST** form is provided to Providence Adult Day Health.

_____ _____
Initials Date

Participant Signature:_____ Date:_____

Signature of Legal Representative:_____ Date:_____

For Agency Use Only

Annual Review: (Indicate Year)

Wishes CPR _____ _____ _____ _____ _____ _____ _____ _____

NO CODE _____ _____ _____ _____ _____ _____ _____ _____

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Fax 509.482.2490

Client Name _____ Social Security #_____

Address _____

_____

Responsible party if different from above:

Name: _____ Social Security #_____

Address _____

_____

ADMISSION CONSENT

I hereby authorize Providence Adult Day Health (PADH) to provide day health care services to me as may be ordered by my physician including photographs that may be necessary for medical records. I have been given information about the care treatment plan and I agree to work cooperatively with the PADH staff towards the attainment of mutually agreed upon goals. I understand that my care plan may include nursing, rehabilitation and/or supportive counseling services. Assessments will be completed by the 10th day of attendance.

PROMISE TO PAY

My daily costs of care and intake assessment fees are listed below. If I am privately funded, I am responsible for payment. I will receive monthly invoices from PADH and payment is due within 30- days. If payment is not received within 30 days, the center may refer my account to a collection agency.

If I have a third party agreement from a government program then that third party payer is responsible for payment and I assign PADH all monies from that government program for services rendered. PADH will be responsible for attaining authorization prior to me attending. If the third party payer does not pay all or part of my balance, I am responsible for payment. If payment is not received within 30 days, the center may refer my account to a collection agency.

PARTICIPANT BILL OF RIGHTS & GRIEVANCE PROCEDURE

I have received a copy of the Providence Adult Day Health Participant Handbook and have read and/or had the Participant Bill of Rights and Grievance Procedures explained to me and I understand their content.

X_____ _____

Participant Signature or Responsible Party's Signature/Relationship to Participant — Date

(*If other than participant signing – I affirm I have the Authority to sign for the participant)*

For Office Use Only

FUNDING INFORMATION

☐ Private Day Health
☐ Private Day Care – Level 1
☐ Private Day Care – Level 2
☐ Medicaid
☐ Veterans Day Health
☐ Veterans Day Care
☐ Respite Care
☐ SCSA
☐ Other

One time Intake and Comprehensive Assessment Fee $_____

# of attendance days _____ M T W TH F

Cost of Care $_____ per day

Request for Fluid Milk Substitution – Adult Care

Adult Participant's Name _____

Non-dairy milk substitution request:

If an adult participant cannot drink cow's milk due to medical or other special dietary needs but does not have a diagnosed medical disability, your provider may choose, but is not required, to provide a non-dairy milk substitute that is nutritionally equivalent to cow's milk, based on your request. At this time, only four brands of non-dairy milk substitutes available in Washington meet the definition of being nutritionally equivalent to cow's milk: 8th Continent Soymilk (Original and Vanilla), Pacific Ultra Soy (Original and Vanilla), Great Value Original Soymilk and Kirkland Organic Soymilk (Plain).

By completing the information below, the adult participant may be served one of these soy milks, provided by the adult care facility (if the adult care facility chooses), or provided by you.

Identify why the adult participant requests a non-dairy milk substitute: _____

_____

_____ I request the adult participant be served the adult care facility provided soy milk as described above for meals that require milk.

_____ I will provide one of the soy milks described above for meals served to the adult participant that require milk.

Providers are required to serve a milk substitution that is nutritionally equivalent to cow's milk if the adult participant has a documented medical disability, diagnosed by a licensed physician, either a M.D. (Medical Doctor) or a D.O. (Doctor of Osteopathy). If the adult has been diagnosed with a medical disability that prevents the adult from consuming cow's milk or one of the approved soy milks listed above, submit a note from the physician identifying the following:

1) The adult participant's disability
2) The major life activities/bodily functions affected by the disability
3) A description of how the disability restricts the adult participant from drinking cow's milk and approved brands of soymilk
4) The prescribed food substitute

Cow's milk substitution request:

Providers may choose, but are not required, to serve lactose-reduced or lactose-free milk or organic milk to adults in their care. If the provider does not serve these milks, the household member/guardian may bring the substituted milk for the adult to consume while in care.

_____I will provide 1% or nonfat lactose-reduced or lactose-free milk to be served in place of the milk served by the provider.

_____I will provide 1% or nonfat organic milk to be served in place of the milk served by the provider.

Signature of Participant/Caregiver: _____ Date: _____

OFFICE OF SUPERINTENDENT OF PUBLIC INSTRUCTION
Child Nutrition Services
Old Capitol Building
PO BOX 47200
Olympia WA 98504-7200

ADULT CARE CENTER
INCOME-ELIGIBILITY APPLICATION

PART 1 – ADULT PARTICIPANT'S INFORMATION

Adult's Name	Age

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD OR FDPIR, OR PARTICIPANT(S) RECEIVING SSI OR MEDICAID—Only one household member receiving Basic Food or FDPIR must be listed in order to establish eligibility for free meals. SSI or Medicaid qualifies only that individual.

Name	Circle One	Case Number or Identification Number
	Basic Food FDPIR SSI Medicaid	
	Basic Food FDPIR SSI Medicaid	

PART 3 – TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Functionally impaired adults living with their parents are considered a "family" separate from their parents. Complete Part 3 only if income eligibility is based on income.

Names (First and Last) List only the participant(s), spouse and dependent children of participant(s)	Gross Income from Last Month (Or net income if self-employed) Tell us how much and how often. If none, write "0".			
	Earnings from Work Before Deductions	Alimony, Child Support	Retirement, Pensions, Social Security	Job Two or Any Other Income
Jane Smith (example)	*$500 / month*		*$400 / month*	*$ 100 / week*
1.	$ /	$ /	$ /	$ /
2.	$ /	$ /	$ /	$ /
3.	$ /	$ /	$ /	$ /
4.	$ /	$ /	$ /	$ /
5.	$ /	$ /	$ /	$ /
6.	$ /	$ /	$ /	$ /

When a participant is qualifying based on Part 3, Total Household Income, the last four digits of the participant's Social Security Number must be provided or the box must be checked that he/she does not have one.

Adult Participant's Social Security Number (last four digits) XXX-XX-_____ ☐ I do not have a Social Security Number.

PART 4 – SIGNATURE AND CERTIFICATION

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and all income is reported. I understand that this information is being given for the receipt of federal funds; that the information on the application may be verified, and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Must be signed and dated by the adult participant or household member or guardian.

SIGNATURE OF ADULT	DATE	PRINT NAME OF ADULT SIGNING
		RELATIONSHIP TO ADULT PARTICIPANT
ADDRESS	CITY/STATE/ZIP CODE	DAY TIME PHONE

PART 5 – PARTICIPANT'S ETHNIC AND RACIAL IDENTITY (You are not required to answer this)

Check the ethnic and racial category of the adult participant. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

No adult participant will be discriminated against because of race, color, national origin, sex, age, or disability.

Race:

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multi-Racial

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Basic Food, Food Distribution Program on Indian Reservations (FDPIR), Supplemental Security Income (SSI) or Medicaid case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

CENTER USE ONLY

☐ Participant(s) are categorically free based on ☐ Basic Food ☐ FDPIR ☐ SSI ☐ Medicaid

Annual Income Comparison: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Participant(s) on this form who are not categorically eligible qualify as follows:

Check one: ☐ Free ☐ Reduced-Price ☐ Above-Scale

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

_____ _____
Signature of Institution's Representative Date

Not valid without signature and date.

IEA Effective Date: If the institution is using the participant/household member/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the participant/household member/guardian signed the form or the immediately following month. If the institution representative does not evaluate and sign the IEA within these guidelines, the institution representative's signature date must be used as the effective date.