GOLDIE'S ADULT MEDICAL DAYCARE
Participant Registration Form

Name: _____ Phone: _____

Street: _____City: _____ State: _____ zip: _____

Date of birth: _____age: _____ Social Security number: _____ Marital status: _____

Religion: _____ date enrolled: _____

Primary caregiver's name: _____ Relationship: _____

Street: _____ City: _____ State: _____ Zip:_____

Occupation: _____ Employer: _____ Work phone: _____

Home phone: _____ Cell phone: _____ Other Phone: _____

e-mail address: _____

Person responsible for payment: _____

Address (if different from above): _____

Please list at least two people we could contact in the event of an emergency if the caregiver cannot be reached. These phone numbers must be current; please let us know if any changes occur.

Name: _____ Relationship: _____ Phone: _____

Additional number(s) for this contact: _____

name: _____ relationship: _____ phone: _____

Additional number(s) for this contact: _____

Participant's primary physician: _____ phone: _____

Other physician(s): _____

Preferred Maryland hospital (please list)_____

Names of person(s) who are authorized to pick up participant from GOLDIE'S ADULT MEDICAL DAYCARE:

_____

NOTE: **If the potential participant has medical assistance, they must have a level of care from Telligen to attend Medical Daycare. To obtain this qualification, there are two courses of action:**

1. **If the potential participant is currently in a hospital and nursing home, a 3871 assessment with a 99.9 procedure code needs to be completed and submitted to Telligen.**
2. **If the potential participant is not in a hospital or nursing home the assessment can be completed through the AERS (Adult Evaluation and Review Services, a Maryland Medicaid program).**

For private pay rates, please contact the program director

Please read the following statement, then sign and date below.

In the event of an emergency, I give permission for _____ to be transported to the nearest emergency room or to my preferred hospital (depending upon the nature of the emergency). I understand that I am responsible for all charges resulting from the emergency care, including ambulance or rescue squad charges. I also give permission for ADC staff to provide emergency medical personnel with any information which will assist them in treatment of the emergency.

Participant/caregiver's signature: _____ date: _____

Participant/caregiver's name (printed): _____

***Please provide ADC with copies of the participant's Social Security card, insurance card(s), and Medicare card which we will keep on file in the event of an emergency.**

GOLDIE'S ADULT MEDICAL DAYCARE

Participant Activities of Daily Living

Participant name: _____ **Start date:** _____

ACTIVITY	INDEPENDENT	NEEDS HELP	UNABLE TO DO
Dressing			
tie shoes	☐	☐	☐
slip-on shoes	☐	☐	☐
socks/stockings	☐	☐	☐
buttons	☐	☐	☐
zippers	☐	☐	☐
Personal Hygiene			
bathing him/herself	☐	☐	☐
teeth/denture cleaning	☐	☐	☐
brushing/combing hair	☐	☐	☐
shaving	☐	☐	☐
toileting	☐	☐	☐
Movement			
in and out of car	☐	☐	☐
rising from chair	☐	☐	☐
walking on level surface	☐	☐	☐
stairs	☐	☐	☐
Eating			
feeds him/herself	☐	☐	☐
cuts meat	☐	☐	☐
knows utensils	☐	☐	☐
prepares a sandwich.	☐	☐	☐

ACTIVITY	NEVER	SOMETIMES	ALWAYS
sleeping problems	☐	☐	☐
wandering	☐	☐	☐
suspiciousness	☐	☐	☐
confusion	☐	☐	☐
repetitious questions	☐	☐	☐
disorientation	☐	☐	☐
agitation	☐	☐	☐
aggressiveness	☐	☐	☐
follows simple instruction	☐	☐	☐
takes medications readily.	☐	☐	☐

ABILITY	NO LOSS	NORMAL LOSS	MODERATE LOSS	SEVERE LOSS
Hearing	☐	☐	☐	☐
Vision	☐	☐	☐	☐
Reading Skills	☐	☐	☐	☐
Writing Skills	☐	☐	☐	☐
Speech	☐	☐	☐	☐

GOLDIE'S ADULT MEDICAL DAYCARE
Participant Cover Sheet

Participant's Name:_____

Primary Insurance:_____
Insurance Number:_____
Secondary Insurance:_____
_____

Primary Diagnoses:_____
_____
_____
_____
_____

Please List Any Medications and Frequency:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

GOLDIE'S ADULT MEDICAL DAYCARE
Waiver of Liability

Participant name: _____ Start date: _____

I hereby give permission for my family member to participate in Goldie's Adult Medical Daycare activities described below. I will not hold any of the Goldie's Adult Medical Daycare's staff, or volunteers responsible for any injury to the above-named participant which occurs during any of the activities listed below:

- Daily activities at the ADC Center
- Administration of prescription medication as prescribed by the participant's physician (Medications must be brought to the center in a labeled, duplicate prescription bottle.)
- Administration of nonprescription medications as requested by the participant's family (Medications must be brought to the center in their original containers.)

Participant/Caregiver signature: _____ date: _____

Participant/Caregiver name (printed): _____ date: _____

Witness signature: _____ date: _____

GOLDIE'S ADULT MEDICAL DAYCARE
Policies and Admissions Agreement

Participant name: _____ Start date: _____

- Hours to be spent at the Center will be based upon the participant's ability level and family need. Hours will be approved by the RN, SW & Center Director and will be reviewed as the participant's ability level changes.
- Days to be spent at the Center will be based upon the participant's ability level and family need. Three to five days per week is recommended but not mandatory for the participant to remain adjusted to the program and to receive maximum benefits from the Center's activities.
- Center hours are from 8:00 a.m. to 4:00 p.m. (with some exceptions). **Late pick-up charges are $5.00 *for each minute* past 4:30 p.m. INITIAL: _____**
- Goldie's Adult Medical Daycare must always have two current emergency numbers on file.
- If transportation to the Center is provided by the participant's family or another caregiver, they will escort the participant into the appropriate activity room or reception area.
- Prescription medications must be brought to or kept at the Center in a duplicate prescription bottle. Nonprescription medications must be in their original container. Medications will be stored in a locked secure area, and participants may not have medication in their possession at *any* time.
- Participants must have had a physical exam within three months prior to enrollment. In the event of an emergency, the preferred Maryland hospital (as indicated on the registration form) will be used.
- Ongoing family/caregiver involvement is essential. Families are encouraged to attend special events, caregiver classes, and support group meetings.
- A family member/caregiver will give the Center **24-hour notice** if the participant is unable to attend on a scheduled day, at which time an alternate day may be scheduled.
- Participants may be suspended or terminated from the program for: (1) behavior that is severely disruptive to activities; (2) behavior that places other clients, staff members, or others in danger; (3) change in medical status which cannot be managed at the Center; (4) communicable diseases; (5) failure of participant's family/caregiver to adhere to Center policies; and (6) failure to pay fees.
- Participants with infectious disease or illness (such as vomiting or diarrhea) are not allowed to attend the Center. Anyone who becomes ill or who is injured at the Center must be picked up by a family member/caregiver within one hour of notification by staff or be available to receive participants at home. A physician's release must be obtained and on file at ADC prior to the participant's re-entering the program.
- Scheduled days on which ADC will be closed will be posted on the Center door and a notice or calendar will be sent home. The Center may also close for severe weather conditions, at which time a message will be left on the Center's answering machine.
- Video monitoring of clients and activities may be utilized at times to ensure client safety, as well as to allow caregivers the opportunity to observe their loved one as he/she participates in the program.
- **For private pay clients, payment is expected within 15 days of receipt of invoice. A late fee of $15.00 may be charged if payment is not received within this time period. INITIAL: _____**

I have read, understood, and agreed to the above GOLDIE'S ADULT ADC policies:

Participant/Caregiver Signature: _____ Date: _____

Participant/Caregiver Name Printed:_____

GOLDIE'S ADULT MEDICAL DAYCARE
Photo Release Form

Participant name: _____ Start date: _____

I hereby give permission for the Goldie's Adult Medical Daycare staff and/or a designated volunteer to (*check each box to which you agree):

- ☐ Take a photographs of the participant
- ☐ Videotape my the participant
- ☐ Record the participant's voice.

Furthermore, I authorize the use and reproduction of these for publicity and/or educational and/or informational purposes without compensation to me or to my family member. All copies and negatives shall constitute the property of GOLDIE'S ADULT MEDICAL DAYCARE.

Participant/Caregiver signature: _____ date: _____

Participant/Caregiver name (printed): _____ date: _____

Witness signature: _____ date: _____

*Please note: Failure to agree to any other items on this release form WILL NOT affect your loved one's participation in the program.

GOLDIE'S ADULT MEDICAL DAYCARE
Grievance Policy Agreement

Participant name: _____ Start date: _____

The GOLDIE'S ADULT MEDICAL DAYCARE program is committed to providing the highest quality of care to our participants, and their families. In the event any aspect of our care has been less than satisfactory, we want to know. We encourage the family or the participant to tell us if he, she, or they are dissatisfied with our care. If you have a complaint or concern, please call: (410) 302-8700

If in the event you have a complaint, inform the Center Director or Clinical Supervisor; you may also communicate directly to the Executive Director/Owner.

A verbal response will occur within 24 hours. A written response is available upon request.

If the complaint is related to the Child and Adult Care Food Program (CACFP) program or Civil Rights, a written allegation and response will be provided to the complainant and to the Maryland Department of Human Services.

If you are not satisfied with our responses, you may communicate directly with the President and/or owners of the Program Services. These names will be made available to you, upon request, to assist with this process.

I have read, understood, and agreed to the above GOLDIE'S ADULT MEDICAL DAYCARE grievance policy:

Participant/Caregiver name (printed): _____ Date: _____

Participant/Caregiver signature: _____ Date: _____

GOLDIE'S ADULT MEDICAL ADC
Medical Information Release Form

To the Doctor(s) of _____

Participant's Name

I hereby authorize you to release to GOLDIE'S ADULT MEDICAL DAYCARE any and all medical or confidential information contained in the record of:

Full name of participant: _____Date of birth:_____

Address:_____

_____

****

I further authorize GOLDIE'S ADULT MEDICAL DAYCARE to release any and all health information contained in the GOLDIE'S ADULT DAY SERVICES health records to any doctor who is providing treatment for

_____
(Participant's Name)

Patient or authorized representative:_____

Date:_____**Phone:**_____

Please fax or mail information to GOLDIE'S ADULT MEDICAL DAYCARE at:

Fax:_____

Address: Goldie's Adult Medical Daycare, 4328 Ritchie Hwy, Baltimore MD 21225

GOLDIE'S ADULT MEDICAL DAYCARE

Medical Information Release Form
(HIPPA Release Form)

By way of my signature, I provide GOLDIE'S ADULT MEDICAL DAYCARE with my authorization and consent to use and disclose protected information for the purpose of treatment and/or financial assistance.

Participant name: _____ start date: _____

Social Security number: _____ date of birth: _____

Patient/Caregiver signature: _____ date: _____

Caregiver relationship: _____

****

I, _____, on behalf of the participant, authorize GOLDIE'S ADULT MEDICAL DAYCARE SERVICES to do the following. I understand this authorization will remain in effect until I provide written instructions otherwise.

PLEASE CIRCLE YOUR CHOICE(S):

- *GOLDIE'S ADULT MEDICAL DAYCARE* ☐ ***may*** / ☐ ***may not*** *call me at work.*
- *GOLDIE'S ADULT MEDICAL DAYCARE* ☐ ***may*** / ☐ ***may not*** *leave a message for me at work.*
- *GOLDIE'S ADULT MEDICAL DAYCARE* ☐ ***may*** / ☐ ***may not*** *release the participant's information to authorized physicians.*
- *GOLDIE'S ADULT MEDICAL DAYCARE* ☐ ***may*** / ☐ ***may not*** *leave message in pone mailbox.*
- *GOLDIE'S ADULT MEDICAL DAYCARE* ☐ ***may*** / ☐ ***may not*** *release the participant's information to authorized providers for possible financial assistance.*

- ☐ ☐ *GOLDIE'S ADULT MEDICAL DAYCARE may / **may not** release the participant's information to the following person(s) or organizations*:
    - Name: _____ phone: _____
    - Name: _____ phone: _____
    - Name: _____ phone: _____

E-MAIL Messages

- ☐ Use my e-mail address to send messages for me to contact the nurse for information ***OR***
- ☐ Use my e-mail to leave detailed messages and information.
- ☐ Attach lab results to the e-mail message.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing.

Patient/Caregiver signature: _____**Date:** _____

Witness Signature:_____**Date:**_____

GOLDIES ADULT MEDICAL DAYCARE

Preparing for Daycare

In addition to all the required paperwork, we ask that you also bring for your loved one:

1. A complete change of clothing (pants, shirt, underwear, socks, etc.) that can be left at the center for emergencies.
2. Any type of protective garment your loved one may use.
3. Social Security, Medicare, V.A., and/or insurance cards (any that you would present upon hospital admission) of which we will make a copy and keep on file.
4. Any legal document that you would present upon hospital admission – Power of Attorney, Healthcare Power of Attorney, Living Will, specific "Do Not Resuscitate" order. We will make copies of these as well.
5. If we are to give any prescription or nonprescription medications during the day, we require that the medicines be in their original containers. Pharmacies are very willing to give a second bottle with the prescription on it if you only ask.

Thank you!

Goldie's
ADULT MEDICAL DAYCARE

Participant's Name:_____

Primary Insurance:_____
Insurance Number:_____
Secondary Insurance:_____
_____

Primary Diagnoses:_____
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Please List Any Medications and Frequency:_____
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