Applicant Name: _____

Senior Services, Inc.

"A Home for the Day"

Adult Day Care Services

84 Social St.
Woonsocket, RI 02895
(401) 766-0516
Fax: (401) 765-5578

Thank you for your interest in our Adult Day program. Attached is your application packet. Please return your completed forms to us as soon as possible.

Your application packet includes:

- Applicant Information
- Financial Disclosure Form
- Authorization for Release of Medical Information

Please review, sign, and return all completed forms to "A Home for the Day".
Thank you!

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APPLICANT INFORMATION

APPLICANT'S NAME: _____

FULL ADDRESS: _____

_____

DATE OF BIRTH: _____

TELEPHONE: _____

ALLERGIES: YES _____ NO _____ (if yes, SPECIFY/REACTION):

_____

_____

SOCIAL SECURITY NUMBER: _____

*We will need a copy of your social security card for our confidential records.

WHO IS COMPLETING THIS APPLICATION? _____

RELATION TO APPLICANT: _____

CONTACT INFORMATION: (Please list primary caregiver first):

NAME	RELATION	ADDRESS	TELEPHONE	EMAIL

_____

_____

_____

_____

PRIMARY CARE PHYSICIAN: _____

TELEPHONE: _____

ADDRESS: _____

OTHER PHYSICIAN(S) INVOLVED IN YOUR CARE: _____

_____

_____

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DECISION MAKING

Do you continue to make your own decisions and sign legal documents? _____

Do you have a power of attorney? YES_____NO_____
**If yes, we will need a copy for your medical record*

Do you have an advance directive? YES _____NO _____
If YES, we will need a copy for your medical record

If NO, are you interested in obtaining information regarding advance directives or a living will?
YES_____ NO_____
*911 will be called for all emergencies and full resuscitative measures will be carried out unless otherwise instructed by the applicant, family and by their physician ***in writing.*** ***Any request for*** DNR, DNI OR CMO-REQUIRE A DOCTORS ORDER. Please inform your doctor of your wishes regarding resuscitative measures. This is part of the information we request from your doctor prior to you starting the program.

HELP US GET TO KNOW YOU

ARE YOU: Single_____ Married_____ Partner_____ Separated____

Divorced_____ Widowed_____

RACE (optional): Indian___ White___ Black/African American___ Hispanic___ Asian____

*PRIMARY LANGUAGE_____

SECONDARY LANGUAGE_____

RELIGIOUS/SPIRITUAL AFFILIATION: Protestant____ Roman Catholic_____ Jehovah Witness_____

Jewish____ Buddhist____ Hindu____ None _____ Other, please specify: _____

Do you have any cultural, spiritual or religious practices that we can support while you are attending our day program? _____

_____

Do you have any cultural or religious food practices?

_____

_____

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PLEASE LIST ANY ONGOING MEDICAL ISSUES:

WHAT IS THE APPLICANT'S/FAMILY'S GOAL FOR ADULT DAY CARE?

PLEASE LIST MEDICATIONS (* if to be given at "A Home for the Day" Adult Day Center):

WHAT ARE YOUR INTERESTS AND EXAMPLES OF THINGS YOU ENJOY?

WHAT WAS YOUR TRADE OR OCCUPATION? _____

Were you in the armed forces? YES _____ NO _____COMMENT: _____

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PHYSICAL NEEDS

Do you need to walk with someone close by? _____
Do you walk with a walker? _____ A cane? _____
Do you use a wheelchair? YES_____ NO _____
Is your vision impaired? YES _____ NO _____
Do you wear glasses? YES _____ NO _____
Do you wear dentures? YES _____ upper ___ lower___ NO_____
Is your hearing impaired? YES_____ NO_____
Do you use a hearing aide? YES_____ left ____ right___ NO _____
Are you incontinent? BLADDER - YES_____ pads_____ briefs_____ NO_____
BOWEL - YES_____ NO _____
Do you have a colostomy, ileostomy or urostomy? YES ____ NO ____ If yes, specify_____
_____

Can you read in your primary language? YES _____ NO _____
Can you write? YES _____ NO _____

ACTIVITIES OF DAILY LIVING

Are you able to dress yourself? YES ____ NO_____
Are you able to shower / bathe yourself? YES ____ NO_____
Are you able to feed yourself? YES ____ NO_____
Do you follow a special diet? YES ____ NO _____ (if yes, SPECIFY):
_____
Do you smoke? YES ____ NO _____
Do you drink alcohol? YES ____ NO _____
Other? _____
Were you recently hospitalized? If yes, why? _____
_____
_____

DO YOU RECEIVE ASSISTANCE WITH ANY OF THE FOLLOWING?
**check all that are appropriate*

Meal preparation _____
Medication management _____
Shopping _____
Housekeeping _____
Paying bills _____

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HOME SUPPORT/ SAFETY

What are your current living arrangements? _____
_____
_____

Are there any safety concerns within the home? _____
_____
_____

Do you receive any home services? YES_____NO_____
IF YES, what services are you currently receiving?
**check all that apply:*

HOMEMAKER _____
NURSING ASSISTANT (C.N.A) _____
NURSING _____
PHYSICAL THERAPY _____
OTHER THERAPIES _____
NAME OF AGENCY _____
PHONE NUMBER OF AGENCY: _____
PRIVATE DUTY CARE _____

ADDITIONAL INFORMATION: _____

_____

_____

_____

_____

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ENROLLMENT

FOR WHICH DAYS IS ATTENDANCE REQUESTED?
**check all that apply*

MON ____ TUE _____ WED ____ THUR _____ FRI _____

ARE YOU REQUESTING THAT WE ARRANGE FOR TRANSPORTATION?
YES_____ NO _____

*Requested AM pick-up time _____
*Requested PM drop-off time _____

TRANSPORTATION IS ARRANGED THROUGH *LOGISTICARE* FOR ELDERS AND DISABLED ADULTS. THIS IS A DOOR TO DOOR SERVICE ONLY. IF THE APPLICANT IS NOT SAFE ALONE, THIS NEEDS TO BE SPECIFIED ON OUR REQUEST FOR TRANSPORTATION AND A REQUEST WILL BE MADE FOR A PERSON TO PERSON DROP OFF. *LOGISTICARE* REQUIRES A MINIMUM OF 48 HOURS NOTICE FOR ALL NEW REQUESTS.

*Comment: _____
_____

IF A FAMILY MEMBER OR CAREGIVER WILL BE PROVIDING TRANSPORTATION, PLEASE PARK IN THE DAYCARE LOT (to the left of the building) AND SIGN YOUR LOVED ONE INTO OUR CARE EACH DAY THEY ARE SCHEDULED TO ATTEND.

_____ _____
DATE APPLICANT'S SIGNATURE

IF UNABLE TO CONSENT, PLEASE COMPLETE THE FOLLOWING:

The applicant is unable to consent because _____

_____ _____
DATE NEXT OF KIN/LEGAL GUARDIAN/POWER OF ATTORNEY

_____
RELATIONSHIP TO APPLICANT

Applicant Name: _____

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FINANCIAL DISCLOSURE FORM

The financial information requested is essential in establishing a fee scale for Adult Care Services. You must complete this form in order to be considered for an adjustment; otherwise, our full fee will be charged. All information is confidential and will not be disclosed. Proof of Income is required: a copy of tax return (if still filing), a copy of Social Security, pension amount award letter, annuities or IRA withdrawal schedule, interest income and other appropriate documents such as bank statements that will show monthly deposits.

MAILING ADDRESS: _____

DATE OF BIRTH: _____

TELEPHONE #:_____

SOCIAL SECURITY NUMBER: _____

PLEASE provide MONTHLY NET INCOME for applicant and spouse:

	APPLICANT:	SPOUSE:
Salary	_____	_____
Social security	_____	_____
Pension	_____	_____
Rental property	_____	_____
Interest/Dividends	_____	_____
Disability	_____	_____
Other	_____	_____
TOTAL $	_____	_____

Applicant Name: _____

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FINANCIAL DISCLOSURE FORM CONTINUED

The following information will help us determine if you are eligible for any additional financial assistance:

INDIVIDUAL assets in savings, checking OR investments are over $4,000? YES _____ NO _____

For a COUPLE, assets in savings, checking OR investments are over $6,000? YES _____ NO _____

OUR CURRENT SLIDING SCALE RATE AS OF 6/2016:

INDIVIDUAL	COUPLE	DAILY RATE
Up to $24,500	up to $33,000	$63
$24,501-34,299	$33,001- $45,199	$65
$34,000-38,199	$46,200 - $51,799	$70
$38,200 & over	$52,000 & over	$75

If your yearly income is less than $24,500 for individual or less than $33,000 for a couple, you may qualify for the copay program. This is a cost share government subsidy program that requires meeting set criteria and requalifying on an annual basis. The copay amounts are $7 or $15 per day depending on above income. Further documentation will need to be completed.
Income verification will be required to be considered for sliding scale or reduced rate. Verification by tax return and or bank statement(s).

I attest that the above information is true to the best of my knowledge:

_____
Signature of applicant or representative

_____
Date

Applicant Name: _____

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MEDICAL RELEASE

I, _____, grant permission to
(PATIENT or PATIENT REPRESENTATIVE)

Dr. _____ To release medical

Information pertaining to _____ to Senior Services, Inc.,
(PATIENT)

"A Home for the Day" Adult Day Care Center.

Patient Name: _____

Patient Date of Birth: _____

Patient's Address: _____

_____

Patient's Phone: _____

SIGNATURE OF PATIENT or PATIENT REPRESENTATIVE:

_____ Date: _____
(PATIENT or PATIENT REPRESENTATIVE)

IF PATIENT REPRESENTATIVE:

Relationship to patient: _____

Patient Representative's Address: _____

Patient Representative Phone: _____