ADULT DAY HEALTH PROGRAM

ENROLLMENT APPLICATION

309 Spring Street
Newport, RI 02840
Tel (401) 849-3204
Fax (401) 519-7476

WHAT IS ST. CLARE-NEWPORT ADULT DAY HEALTH PROGRAM?

St. Clare-Newport Adult Day Health Program is a safe, comfortable day program staffed by caring and skilled individuals who provide individualized and comprehensive health, personal care, social and therapeutic services.

WHO IS ELIGIBLE TO ATTEND?

- Individuals who have a confirmed diagnosis of cognitive impairment, including Alzheimer's Disease and other dementias
- Individuals who have cardiac diseases including CHF, CAD, and A-fib; pulmonary disorders such as COPD and emphysema; neurological disorders such as Parkinson's Disease and history of stroke; and those with diabetes
- Individuals who have a need for assistance with meal preparation; treatments/medication administration; personal hygiene including bathing, dressing or grooming; nutritional counseling; or ongoing assessment of health status
- Individuals who would benefit from structured, meaningful activities which encourage social stimulation and engagement.

MISSION AND PHILOSOPHY OF ST. CLARE-NEWPORT ADULT DAY HEALTH PROGRAM

- It is the mission of St. Clare-Newport to improve the quality of life for its family and community through care and service.
- It is the philosophy of St. Clare-Newport to provide programming to individuals that focuses on the whole person and their family. The goal will be to provide services that enhance and complement other community services that are in place and maintain functional status and non-institutional community residence.

HOURS OF OPERATION AND NONDISCRIMINATION POLICY

- St. Clare-Newport Adult Day Health Program is open Monday through Friday from 8:00 a.m. to 4:00 p.m.
- Half day programming is available, and hours for half day participation can be arranged according to the participant's needs.
- St. Clare-Newport Adult Day Health Program will not discriminate in serving any person on the basis of race, color, sex, national origin, age, mental or physical disability, or veteran status.

HOW TO ENROLL IN ST. CLARE-NEWPORT ADULT DAY HEALTH PROGRAM

- If you have any questions or concerns, feel free to contact the program director, Christy L Ross, RN at (401) 849-3204 ext. 734 or the case manager at ext. 719. We can arrange for a tour of our facility and/or schedule an intake appointment.
- Please drop off completed forms during hours of operation or mail to:

  St. Clare-Newport Adult Day Health Program
  309 Spring Street
  Newport, RI 02840

Services Provided by St. Clare-Newport Adult Day Health Program

Health Care:

Care provided by a registered nurse

- Monthly health assessments: BP, pulse, respiration, temperature and weight
- Medical follow-up and care coordination with participant's private physician
- Multidisciplinary care planning
- Nutritional supervision and management of special diets

Health care may also include services as needed

- Dispensing of medications by a registered nurse (RN) or a certified med tech (CMT)
- Dressing changes
- Injections (e.g. insulin)
- Health assessments
- Outpatient services (PT, OT, SLP, aqua therapy) are available onsite through Innovations Rehabilitation

Personal Care:

- Showers provided weekly and as needed by certified nursing assistants (CNA)
- Toileting assistance
- Hair dressing services (wash, cut, styling, color, perm), manicure and massage provided in house for an additional fee

Nutrition:

- Lunch and 2 snacks are provided for full day program, lunch and 1 snack are provided for half day participation
- Feeding assistance and cueing for meals as needed

Program Activities:

- Arts and crafts
- Exercise, movement therapy
- Music therapy
- Entertainment
- Reminiscence
- Games, both hands-on and those for mental/cognitive stimulation
- Trivia and sing-alongs

Social Services/Care Management:

- Care coordination for in home services, therapeutic services (OT/PT/SLP), and scheduling appointments
- Support groups for caregivers
- Assistance with long term care planning

Application for Enrollment

St. Clare-Newport Adult Day Health Program, 309 Spring Street, Newport, RI 02840
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Name: _____ Prefers to be called: _____

Address: _____ Phone: _____

Date of Birth: _____ Age: ____ Social Security Number: _____

Sex: _____ Race: _____ Marital Status: _____ Primary Language: _____

Medicare: _____ Medicaid: _____

Other Health Insurance: _____ Policy Number: _____

Caregiver's Name: _____ Relationship: _____

Contact Information: Home #:_____ Work #: _____ Mobile #:_____

Secondary Contact: _____ Relationship: _____

Contact Information: Home #:_____ Work #: _____ Mobile #:_____

Primary Care Physician: _____ Phone: _____ Fax: _____

Preferred Hospital: _____

Drug/Food Allergies (indicate reaction): _____

_____

Medical Diagnoses/Surgical History: _____

_____

_____

Psychiatric Diagnoses/History: _____

_____

Hospitalization in the last year: _____

Advanced Directives: _____ FULL _____ DNR _____ DNR/DNI _____ CMO _____ MOLST
Living Will: _____ Yes _____ No

Power of Attorney/Medical: _____ Phone: _____

Power of Attorney/Financial: _____ Phone: _____

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How did you hear about our program (reference, advertisement, etc.)? _____

How many days of attendance are requested? _____

Which days of the week are preferred? _____

Will potential participant be attending a _____Full Day _____Half Day?

How will participant be transported to the program and how do they tolerate transport: _____

_____

Does potential participant take medications: prescribed, over the counter or PRN (as needed)? ___Yes __No
If yes, please list: _____

_____

Does potential participant have a prescribed diet or require assistance with feeding? _____Yes _____No
If yes, please explain: _____

_____

Does potential participant require assistance with ambulating? _____Yes _____No
If yes, please explain (use of walker, cane, requires personal assist) _____

_____

Is potential participant incontinent of bladder or bowel or need assistance in bathroom? _____Yes _____No
If yes, please explain: _____

Private Pay Fee Schedule as of August 7, 2017

Full Day	**$88.00**
Half Day	**$48.00**

*** Please speak to us about other payment options.**

_____ _____
Applicant's Signature Date

_____ _____

Legal Guardian/Power of Attorney Date

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Background/Activity Interests

Name: _____ **Maiden Name:** _____

Date of Birth: _____ **Birth Place:** _____

Marital Status: _____ **Spouse's Name:** _____ **Number of yrs married:** _____

Number of Children: _____ **Names:** _____

Places lived: _____

Places traveled: _____

Education: _____

Occupations: _____

Religion/Spiritual Needs: _____

Activities of Interest:

_____ Games _____ Pets/Animals _____ Television _____ Gardening _____ Music _____ Crafts

_____ Sports _____ Woodworking _____ Spiritual _____ Movies _____ Exercise _____ Walking

_____ Reading _____ Painting/Drawing _____ Nail Care _____ Sewing _____ Cooking _____ Puzzles

Others/Details: _____

Activities Disliked: _____

Clubs, Organizations and Volunteerism: _____

_____

Food/Drink Preferences:

Likes: _____

_____

Dislikes**:** _____

_____

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Pre-Enrollment Medical Form
(to be completed by the participant's physician)

Patient's Name: _____ D.O.B. _____

Address _____ City_____ Zip_____

Past and Present Diagnoses (Please place check on appropriate lines.)
Dementia Diagnosis: ____ Alzheimer's ____Vascular ____Mixed ____Other:_____
Medical Diagnosis: ___HTN ___CAD ___AFIB ___PVD ___Hypercholesterolemia ___CHF ___COPD ___Emphysema ___Diabetes ___CVA ___Parkinson's Disease ___IBD ___GERD ___Osteoarthritis ___Thyroid disorder ___Depression ___Anxiety ___Cancer/Type: _____
Other: _____
Does patient have any food or medication allergies? ___ No ___Yes (Please list):_____
_____
Does patient have any special dietary requirements and/or difficulty swallowing? ___No ___Yes
If yes, please describe: _____

To the best of my knowledge patient:

Does	**Does not have**		**Immunizations**	**Date**
____	**____**	Active TB	Pnemococcal	_____
____	**____**	Hepatitis C	Influenza	_____
____	____	Hepatitis B	Tetanus	_____
____	____	Other active disease	Other	_____

Vitals/Height/Weight during last physical exam **Date of Last Exam: _____**
Height: _____ Weight: _____ Temp: _____ Blood Pressure: _____ Pulse: _____
RR: _____ SpO2: _____ Oxygen Use: ____ Liters Lung Sounds: _____
Please include discharge summary if the patient has been hospitalized within the last 3 months.

Functional Status
Does the patient ambulate independently? _____Yes _____No
If not, what assistive device or assistance is required? _____
Other limitations to patient's participation in program activities? _____
If patient is incontinent, please specify type(s): _____Urine _____Fecal

Cognitive Function
MMSE or other estimate (please describe): _____
Problem behaviors: _____

Current Medications and Dosage (please attach current medication reconciliation):_____
_____
_____
*** At time of enrollment, St. Clare-Newport will require medication orders signed by participant's physician.**

Physician _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____
Preferred Hospital _____ Physician's Signature _____ Date _____

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ADVANCE DIRECTIVES

The participant, _____, the family and the attending physician are in agreement that the directives checked below should provide the parameters for care to the participant named above.

(Check all that are to apply)

_____ **FULL CODE**. St. Clare-Newport staff will initiate CPR, call 911 and inform ambulance personnel of participant instructions that full life saving methods are to be utilized as the responding medical staff deems appropriate including but not limited to use of mechanical devices (defibrillators, respirators) to maintain circulation and respiration.

_____ **DO NOT RESUSCITATE (D.N.R.).** Refers to the withholding of emergency resuscitation in the event of the cardiac arrest. (No CPR, No Intubation's, No defibrillation.) It is appropriate in the following instances, however it is not limited to; those with terminal illnesses, serious or disabling conditions in which recovery is not expected and the frail elderly who would suffer greatly as a result of CPR.

_____ **DO NOT HOSPITALIZE (D.N.H.)** Remaining at the facility instead of transferring him/her to the hospital in the event of an emergency that is life threatening.

_____ **I WISH TO GO TO THE HOSPITAL** for circumstances that are reversible such as pneumonia or fractured hip.

_____ **NO IV INSERTION**. I do not wish intravenous hydration.

_____ **NO G-TUBE**. I do not wish an insertion of a G-Tube for nutrition.

_____ **ANY FURTHER INSTRUCTIONS**_____

_____ _____
(Participant [if capable]) (Date)

_____ _____
(Durable Power of Attorney) (Date)

_____ _____
(Responsible Party) (Relationship) (Date)

_____ _____
(Witness) (Date)

_____ _____

(Physician) (Date)

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RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

PARTICIPANT'S NAME: _____DATE OF BIRTH: _____

RESPONSIBLE PARTY_____
Name Address Tel. No.

PARTICIPANT'S PRIMARY CARE PHYSICIAN: _____

I, _____ and/or _____
(Responsible party) (Participant)

authorize the release of pertinent information for the purpose of follow-up medical and nursing management.

_____ Medical Records

_____ Discharge Summary

_____ Lab Reports

_____ X-Ray Reports

_____ E.K.G.

_____ E.E.G.

_____ Other (i.e. CAT Scans, Invasive/Non-Invasive Testing)

Note: Transfer of records (including date of service) is essential when a resident is hospitalized.

Any information other than the above list requires additional authorization.
THIS AUTHORIZATION MAY BE WITHDRAWN AT ANY TIME.

_____ _____

(Participant's Signature) (Date)

_____ _____

(Responsible Party's Signature and relationship) (Date)