The Caring Place Adult Day Care Center
Application for Enrollment

Participant Information

Enrollment Date: ____________

Participant Name: ______________________________ Nickname: ______________

Address: ____

City: ______________ State: ____ Zip: __________ Sex: M __ F __

Telephone Number: ____________ Date of Birth: __________ Age: ______

Medical Insurance Provider: ____________ Policy Number: ______________

Group Number: ______________

Does the Participant have a Court Appointed Guardian? N __ Y __

Name: ______________________ Phone Number: ______________

Caregiver Information

Caregiver Name: ____________________ Relationship: ______________

Address: (if different): ______________________________________

City: ______________ State: ________ Zip: __________ Sex: M __ F __

Telephone (Day): ____________ (Night): ______________

Services Agreement

A $150.00 Registration fee will be collected at the time of enrollment. A credit will be given on your first invoice for services received.

Adult Day Care Services: (check one that applies)

__ Two Days Tuesday and Thursday, 9:00 am - 3:00 pm - Weekly Total Cost: $144.00

__ Four Days Monday - Thursday 9:00 am - 3:00 pm - Weekly Total Cost: $288.00

Payment options:

__ Paid weekly, on Thursday of each week, OR

__ Paying monthly on the first Thursday of each month, total amount will vary depending on # of days in each month during the year.

Note: Both options, preferably paid by autopayment from your bank or credit card. If paid by credit card, a 3% additional charge will be added to your invoice to cover credit card processing fees.

Source of Payment Options: (check all that apply)

__ Private Pay __ Medicaid: Medicaid ID Number: ____________________

__ I am eligible to receive Medicaid benefits and have already been approved.

__ I do not know if I am eligible for Medicaid benefits, and need assistance in making an application.

__ I understand that if I am eligible for Medicaid benefits, I would not be eligible for a Caring Place scholarship, should their be available funds.

__ I am interested in obtaining information for annual and semi-annual grants from Area Agency on Aging and Arkansas Alzheimer's Assocation for assistance with payment of my services obtained at the Caring Place.

Participant Health Information (check applicable boxes)

Dementia Diagnosis: __ Alzheimer's __ Stroke __ Parkinson's __ Unknown

Other: ____

____

Is the participant aware of the diagnosis? __ Yes __ No

Primary Physician(s): 1. Name, Address, Phone: ______________________________

____

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2. Name, Address, Phone: ______________________________

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____

3. Name, Address, Phone: ______________________________

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____

Date of last medical evaluation: ______________

Overall Rating of Physical Health at Present: __ Excellent __ Good __ Fair __ Poor

Special Health Conditions (Please check all that apply):

__ Seizures
__ Diabetes
__ Osteoarthritis
__ Problems Swallowing
__ History of Falling
__ Osteoporosis
__ Heart Problems
__ Stroke
__ Blood Pressure __ High __ Low

Past Surgeries (please use separate page of paper, if necessary)

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____

____

____

Other (Please specify)

____

____

____

Diet Consistency: __ Regular __ Soft __ Chopped __ Pursed

Special Equipment Used: __ Hearing Aid __ Glasses __ Dentures: __ Upper __ Lower
__ Walker __ Cane __ Eating Utensils __ None

Allergies: __ No known allergies

Medication Allergies: ____________________

Food Allergies: ____________________

Environmental Allergies: ____________________

Toileting Habits (Check all that apply):

__ Independent __ Independent with Pads __ Needs Reminders __ Needs Assistance

__ Lacks Bladder Control __ Lacks Bowel Control __ Behavioral Problems Related to Toileting

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

____

hat

____

____

Behaviors Exhibited by Participant (Check all that apply):

__ Agitated __ Cooperative __ Physically Aggressive __ Sociable
__ Verbally Aggressive __Wandering __ Withdrawn __ Worse in the Evening

Explain: ____________________

____

____

____

Participant Social Information

The following information will assist us in encouraging the participant to maximize his/her abilities, socialization, and self esteem.

Languages Spoken (past or present) ____________________

Former Occupation ____________________

Club Memberships (past or present) ____________________

How does the participant usually spend an average day? ____________________

____

Interests past and present (Check all that apply):

__ Reading	__ Radio	__ Music	__ Singing	__ Games	__ Sports
__ Lectures	__ Gardening	__ Crafts	__ Movies	__ Sewing	__ Handiwork
__ Church	__ Concerts	__ Cooking	__ Exercise	__ Outings	__ Conversation
__ Walking	__ Grooming	__ Pets	__ Collector	__ Travel	__ Woodworking

Housing: __ Apartment __ Home __ Retirement Home __ Assisted Living Facility

__ Foster Care Facility Other: ____________________

Living Situation: __ Lives Alone __ Lives with Spouse __ Lives with Adult Child

__ Lives with Other Relative __ Lives with non-Relative __ Lives with Hired Caregiver

Ethnicity: American Indian or Native American Hispanic Asian/Pacific Islander

Black, non-Hispanic Caucasian, non-Hispanic __ Declined to Respond

Other: ____________________

Religion: ____________________

Highest Educational Level Achieved: __ Grammar School __ GED __ High School/Vocation

__ College __ Graduate School

Annual Household Income: __ Less than $10,000 __ $10,000 - 20,000

__ $20,000 - 40,000 __ More than $40,000

Responsible Party/Spouse Information

Name of Spouse or Nearest Relative: ____________________

Address: ____________________ City: ____________ State: ____ Zip: ________

Relationship to Participant: ____________ Telephone Number: ____________

Other Means of Contact (Pager, Cell, Work Phone, Etc.): ____________________

Person Responsible for Payment: ____________________

Address: ____________________ City: ____________ State: ____ Zip: ________

Relation to Participant: ____________ Telephone Number: ____________

Occupation/Employer: ____________________

If Self-Employed, Name of Business: ____________________

Address of Business: ____________________

I understand this information is confidential and will not be released to any other person without written permission.

Signature of Registrant/Responsible Party: ____________________

Date: ____________