PARTICIPANT REGISTRATION FORM

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Email: remedyadcc@gmail.com Website:www.remedyhomehealthllc.org

PERSONAL INFORMATION

Full Name :

Date of Birth : Gender :

Address :

Resonsible for self: Power of Attorney: Guardian:

City : State/Province :

Zip/Postal Code : Marital Status: :

Phone Number : Language Spoken:

Insurance Provider: Member ID:

Particiant resides with: Phone #:

Transportation Provider: Phone Number:

Drop Off Time: Pick Up Time:

PARTICIPANTS CONTACT INFORMATION

Emergency Contact: : Relationsip :

Address:

Phone #1 : Phone #2 :

Guardian Contact: Relationsip :

Address:

Case Manager Agency Information :

Name: Relationsip:

Address:

Phone #1 : Phone #2:

Email Address:

PARTICIPANT REGISTRATION FORM

RELEASE OF INFORMATION

I _____recognize that by initialing and signing this release, I am

I _____ **RELEASE OF RESPONSIBILITY**

I would like to attend Remedy Home Health Care ADCC Center and participate in the regularly scheduled activities. I acknowledge my participation in all activities sponsored by Remedy Home Health Care ADCC Center as voluntary and will not hold the Center nor any employees or volunteers responsible for any illness or accidents that may occur while I participate in the program. I understand financial liability incurred due to transport, treatment, or extended care resulting from an accident or illness while in attendance Remedy Hoem Health Care ADCC Center is my sole responsibility.

I _____ **CONSENT FOR RELEASE OF INFORMATION**

I hereby allow the release of any of my information to the following individuals:

1) Case Manager:_____

2)Other:_____

3) Other:_____

I understand that only the above-listed individuals will be given information pertaining to this participant. I understand that I am responsible for keeping this list up to date and do not hold Remedy Home Health ADCC Center if I fail to do so.

I _____ **CONSENT FOR RELEASE OF MEDICAL INFORMATION**

I hereby allow the release of any of my medical and other information related to my health to Remedy Home Health ADCC Center. I understand that my medical history will only be used for professional purposes and will be held confidential.

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REMEDY
HOME HEALTH LLC

RELEASE OF INFORMATION

I _____ **EMERGENCY MEDICAL TREATMENT**

I hereby authorize consent for medical treatment, in the case of an emergency, by the nearest medical facility. It is the policy of Remedy Home Health LLC ADCC that permission is granted to receive medical care treatment, so no delay in care arises during the case of emergency.

I _____ **PHOTO RELEASE**

I hereby authorize Remedy Home Health LLC ADCC to photograph and video record me engaging in activities during in-house and community events and to utilize these images in newsletters and promotional materials.

I _____ **CONSENT/WAIVER TO PARTICIPATE IN ACTIVITES**

I hereby release Remedy Home Health LLC ADCC from any liability that may arise when participating in day programming activities such as community outings, recreational activities, and skill development activities.

I _____ **TRANSPORTATION CONSENT/WAIVER**

I consent to transportation via agency van or public transportation to and from community activities. I hereby release Remedy Home Health LLC ADCC from any claims that may arise in said regards.

I _____ **PARTICIPANT RIGHTS**

This is to confirm that I have received a copy of the Participant Rights and Responsibilities for services provided by Remedy Home Health LLC ADCC. These rights have been explained to me in a manner I understand, and I have been given the opportunity to ask questions.

Signature: _____ Date: _____

Participant or Guardian

PARTICIPANT REGISTRATION FORM

REMEDY HOME HEALTH LLC

HEALTH REPORT

Remedy Home Health ADCC Center shall require that each participant, before admittance into the program, present a statement from a physician indicating that the participant does not have any communicable disease, illness, or disability that would interfere with the participant's ability to participate in the program.

Instructions: Remedy Home Health ADCC Center shall provide each participant with a copy of this form to be taken to a health care provider. A signature on the bottom of the document by a healthcare provider establishes compliance with the above requirements. This form is required to be filed for participant record with Remedy Home Health ADCC Center.

Name: (First, MI, Last)		**DOB:**
Date: MANTOUX Tuberculin Skin Test	Date: MANTOUX Tuberculin Skin Test Results	If positive, was a chest X-Ray completed? Yes____ Not____
Comments:		
AUTHORIZATION		
I cerfity, based upon my examination that this person appears to be free of disability, communicable disease or illness transmitted through normal contact, which would interfere with the staff person's ability to participate in program activities.		
Signature: Physician or health check provider	Name: Examination Health Professional	
Address: Health professional office		Date: Examination

MEDICIATION ADMINISTRATION

Remedy Home Health ADCC is a state licensed Adult Day Care Program that provides a broad spectrum of day program services to meet the needs of individuals with a wide range of disabilities. Before Remedy Home Health ADCC staff can dispense or administers a prescription medication to a participant the program must obtain a written order from the physician who prescribed the medication specifying that Remedy Home Health LCC staff are permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered.

According to the Medical Wavier 202.06 (4)(2) A Participant shall control and administer his or her own medications except when the Participant is not able to do so, as determined by the Participant's physician.

I _____,
Primary Physician for _____have determined the following:

_____The participant can control and administer their own medication.
_____The staff at Remedy Home Health ADCC will assist the participant with their medications. It is understood that they will keep record of all medication given including dose, time and conditions ofmedications administered. I will also provide Remedy Home Health ADCC with a copy of all medication orders that they will keep in the participants file.

Remedy Home Health ADCC staff are permitted to administer the following medication to:

Patient Name: _____ Sex: _____ DOB: _____

MEDICATIONS	
Medication/Dosage	Times to be given/Frequency

I authorize Remedy Home Health ADCC personnel to assist in the administration of medications described above to the participants named above.

Physician Signature_____Date_____

Office Address: _____ Phone:_____

INTAKE ASSESSMENT

Participant Name:_____ Date Completed:_____

FUNCTIONAL LEVELS

sight		not impaired		impaired		blind	
hearing		not impaired		impaired		deaf	
speech		not impaired		impaired		aphasic	

COMMENTS

ACTIVITIES OF DAILY LIVING

	Self	with assistance	total assistance	comments
Eating				
Toileting				
Menstrual				
Urinary	continent	incontinent	catheter	
Bowel	continent	incontinent	colostomy	
Bathroom schedule				
Mobility	ambulatory	cane/walker	wheelchair	
Mobility Assistance		1 person	2 person	total assist

COMMENTS

DIETARY NEEDS

SPECIAL DIETARY NEED/RESTRICTIONS/FOOD ALLERGIES:

ADAPATIVE EQUIPMENT NEEDED FOR EATING/DRINKING:

INTAKE ASSESSMENT

PSYCHOSOCIAL/BEHAVIORAL LEVEL

	Never	Occasionaly	Frequently	Comments
wanders				
noisy				
disoriented				
withdrawn				
combative				
delusional				
impaired judgement				
sexual behavior				

DISPLAYS INAPPRORIATE BEHAVIOR(IDENTIFY BEHAVIOR)

FALL RISK SCREENING

How many times have you fallen in the last year? __

Are you worried that you may fall? __ Not at all __A little __Somewhat __Very seldom

Can you say what makes you more likely to fall?

Any serious injuries in the last year?

MEDICATION LIST /DOSAGE/TIME

INTAKE ASSESSMENT

SAFETY
Is there a concern that the participant may wander from the group?
Will the participant recognize belongings?
Is the participant able to recognize danger?
Will the participant be able to participate in group activities?
Other safety concerns?

PERSONALITY
What activities/things frustrate the participant?
What kind of activities does the participant like to participate in?
What is the strategy that can be used to redirect negative behavior(s)?
Is there any additional assistance we can provide to the participant to ensure success in the day program setting?

DAY PROGRAM ACTIVITIES OF INTEREST

	cooking/baking		gardening		grooming
	arts/crafts		board games		puzzles
	music		bingo		mobile library
	community outings		computers		exercise
	movies		pet therapy		celebrations
	therapy		spiritual opportunities		socialization
	entertainment		health monitoring		crosswords

PARTICIPANT ADVANCE DIRECTIVES & DNR STATUS

Advance Directives and DNR StatusAdvance Directives:

□ I have an Advance Directive (Living Will, Health Care Proxy, Durable Power of Attorney for Health Care).

□ I do not have an Advance Directive at this time.

If you have an Advance Directive, please provide a copy to the facility for inclusion in your file.

Primary Health Care Proxy/Agent Name:_ _

Phone Number: _

DNR (Do Not Resuscitate) Status:

□ I have a valid DNR order. (Please attach a copy.)

□ I do not have a DNR order.

□ I would like to discuss a DNR order with my healthcare provider.

Note: Remedy Home Health LLC ADCC will comply with all applicable laws regarding Advance Directives and DNR orders. In the absence of a documented DNR, emergency medical services will be contacted in the event of a life-threatening situation.

Participant or Legal Representative Signature:

_ Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Staff Review Signature:

_ Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _