3924-26 Main St., Ste. 102
East Chicago, IN 46312
www.regaladultdayservices.com
(219) 413-5244
(219) 413-5245

Applicant General Information

Name: _____ Preferred name to be called: _____

Address:_____

City / State / Zip Code: _____ Phone: _____

Applicant Personal Information – This information will remain confidential.

Social Security Number _____-___-_____ Medicare Number _____ Birth Date _____/_____/_____

Medicaid Recipient Number _____

Age: _____ Height: _____ Weight: _____ Sex: ____ Male ____Female

Primary Caregiver or Responsible Person Information

Name:_____ Relationship to applicant: _____

Address: _____

City / State / Zip Code: _____ Home Phone: _____

Work Place: _____ Work Hours: _____

Work Phone: _____ Pager Number: _____

Mobile Phone: _____ Other Phone: _____

Email: _____

Is the billing address the same? ___ Yes ___ No *(If no, please provide correct information below.)* ___ *Medicaid Waiver* ___ *VA* ___ *Choice*

Case Manager _____ ____*Other Insurance/Policy #*_____

Billing Name: _____

Billing Address: _____ City / State / Zip Code: _____

How did you find out about Regal Adult Day Services? _____

Photo here

Applicant ______________________________ Caregiver ____________________________

Advance Directives

___Power of Attorney ____Living Will ____Do Not Resuscitate ____None ____Letters of Guardianship
___Letters of Conservatorship ____Designated Power of Attorney ____Other ________________________

Power of Attorney's Name:____

Please provide a copy of document noted above.

Emergency Contacts and Persons Authorized to Transport Applicant (other than primary caregiver listed on page 1)

Name: ____ Relationship to Applicant: ______________________

Address: ______________________________________ City / State / Zip Code: ________________________

Home Phone: ___________________________________ Work Place: ________________________________

Work Hours: ____________________________________ Work Phone: _______________________________

Other Number: __________________________________ Mobile Phone: ______________________________

Email address: ____

Name: ____ Relationship to Applicant: ______________________

Address: ______________________________________ City / State / Zip Code: ________________________

Home Phone: ___________________________________ Work Place: ________________________________

Work Hours: ____________________________________ Work Phone: _______________________________

Other Number: __________________________________ Mobile Phone: ______________________________

Email address: ____

Name: ____ Relationship to Applicant: ______________________

Address: ______________________________________ City / State / Zip Code: ________________________

Home Phone: ___________________________________ Work Place: ________________________________

Work Hours: ____________________________________ Work Phone: _______________________________

Other Number: __________________________________ Mobile Phone: ______________________________

Email address: ____

Applicant _____ Caregiver _____

Emergency Contacts and Persons Authorized to Transport Applicant (other than primary caregiver listed on page 1)

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

Email address: _____

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

Email address: _____

Primary Physicians – Hospital Preference

Doctor's Name: _____ Doctor's Name: _____

Specialty: _____ Specialty: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

Hospital Preference: _____ Last time hospitalized: _____

Reason: _____ Length of Stay: _____

Long-term effects: _____

Applicant _____ Caregiver _____

Applicant Assessment

If you answer yes, please explain:

Has there been any recent ☐ Weight loss: ☐Gain? No Amount: _____lbs. How Long: _____
Are there any Drug Allergies: ☐Yes ☐No What Drugs:_____Type of reaction:_____
Are there any Food Allergies: ☐Yes ☐No What Foods: _____Type of reaction _____
Does he/she smoke/chew/dip ☐Yes ☐No How Much?_____
Can the applicant read? ☐Yes ☐No
Does the applicant write? ☐Yes ☐No
Is the applicant ☐Left handed? ☐Right handed?
Any history of accidents? ☐Yes ☐No If yes, details:_____
History of illnesses, impairments, accidents Details:_____
_____
Mental status: Please explain:_____
_____

Hearing Impairment:

Right Ear: ☐ No hearing loss ☐Some hearing loss ☐Complete hearing loss ☐Hearing Aid ☐Refuses to wear aid
Left Ear: ☐ No hearing loss ☐Some hearing loss ☐Complete hearing loss ☐Hearing Aid ☐Refuses to wear aid

Visual Impairment

Left Eye ☐ No impairment ☐Cataracts ☐Implants ☐Other _____
Right Eye ☐ No impairment ☐Cataracts ☐Implants ☐Other _____
Glasses ☐ Reading ☐Distance ☐Bifocals ☐Does not wear, explain_____

Dentures: ☐Yes ☐No
Upper ☐Full ☐Partial ☐No teeth ☐Removable bridge
Lower ☐Full ☐Partial ☐No teeth ☐Removable bridge

Describe how well you think the applicant functions in the following areas.

Walking

Steady on his/her feet ☐Yes ☐No
Without any help ☐Yes ☐No
With some help ☐Yes ☐No Explain: _____

☐Cane ☐Crutches ☐Walker ☐Wheelchair ☐Supervised walking ☐One to One assistance

Eating

☐Without help ☐Some help _____ ☐Needs to be prompted to eat

Other considerations: _____

Swallowing

Does the applicant have problems swallowing his/her food? ☐Yes ☐No
Does the applicant store food in his/her mouth? ☐Yes ☐No
Does the applicant have problems drinking ☐Yes ☐No ☐Need thickening: to what consistency:_____
_____

Diet

☐Regular ☐No Extra sugar ☐No extra salt ☐Other restrictions _____

Appetite:

☐Good ☐Poor ☐Eats too fast

Please list any food dislikes:

Applicant _____ Caregiver _____

Applicant Assessment (continued)

Toileting
Bowel and Bladder:
Incontinence of Bladder ☐Yes ☐No ☐ Nighttime only
Incontinence of Bowel ☐Yes ☐No ☐ Nighttime only

Products used in daytime: ☐ Nothing ☐Panty liner ☐Pads ☐Adult diapers ☐Other _____

Help required: ☐None ☐Reminders ☐Physical Assistance ☐Positioning ☐Supervision ☐Hygiene ☐Diapers

Any other toileting concerns? If so, please explain:

Dressing
Help required: ☐None ☐Lay out clothing ☐Supervise only ☐Verbal cuing ☐Physical Assistance ☐Cooperative ☐Resistant

Behavior (Please check all that apply)

Communication
☐ Difficulty communication wants and needs
☐Difficulty completing sentences
☐ Sentences do not make sense
☐ Difficulty naming people
☐ Difficulty expressing self Please explain:_____
☐ Has difficulty concentrating on a task or activity
☐Takes little or no interest in activities and will not start them by self
☐Often asks the same questions over and over again
☐Loses or misplaces objects
☐Has difficulty following simple instructions
☐Hoards objects
☐ Wanders away from home # of times____ ☐Wander's bracelet ☐Medic Alert Bracelet
☐ Cannot be left alone, must be supervised
☐ Demands constant attention and will not let you out of sight
☐ Becomes verbally abusive When:_____
☐ Becomes combative When: _____
☐ Becomes anxious When: _____
☐ Becomes agitated When: _____
☐ Becomes stubborn or uncooperative When: _____
☐ Engages in embarrassing or socially inappropriate behavior How: _____
☐ Talks to people he/she doesn't know
☐ Denies or seems unaware that anything is wrong
☐ Reports seeing or hearing things that are not there
☐ Frequently appears depressed or withdrawn
☐ Engages in behavior that is potentially dangerous to self or others What? _____

Please list any other behavior that you may be aware of:

Personality
Before onset of illness _____ Current _____

Patter of relating to others ☐Outgoing ☐Involved ☐Social ☐Loner

Applicant _____ Caregiver _____

Applicant Assessment (continued)

Primary caregiver ☐Spouse ☐Child ☐Other_____

Who would you say is the primary person responsible for Applicant? _____

Does primary caregiver live with applicant ☐Yes ☐No
If no, living arrangements: ☐Lives alone ☐Spouse ☐Relative ☐Hired caregiver ☐Other

Is primary caregiver employed? ☐Full time ☐Part time ☐Does not work ☐ Will work in future

Does the primary caregiver attend a support group? ☐Yes ☐No
Does or has any other family member had AD? ☐Yes ☐No
Family Goals for daycare ☐Socialization ☐Stimulation ☐Family relief ☐Supervision ☐Other_____

Names that the applicant most remembers: Name_____ Relationship to participant_____

Name_____ Relationship to participant_____

Applicant interests (Current and past.)

Previous occupation: _____ Work Place_____

	Current	Past		Current	Past		Current	Past
Listening to music	☐	☐	Singing	☐	☐	Playing instrument	☐	☐
Sports	☐	☐	Games	☐	☐	Exercising	☐	☐
Knitting/Sewing	☐	☐	Drawing/Painting	☐	☐	Cooking/Baking	☐	☐
Gardening	☐	☐	Walking	☐	☐	Looking at Magazines	☐	☐
Handyman/Mr. Fixit	☐	☐	Dancing	☐	☐	Traveling	☐	☐
Children	☐	☐	Grandchildren	☐	☐	Other_____	☐	☐

How does the applicant currently spend his/her day?

Name of person completing this form (please print)_____

General Applicant Data – Optional – For statistical Purposes only

Gender ☐Male ☐Female Place of Birth: _____ Ethnic Background:_____

Year emigrated to US_____ Primary Language Spoken ☐ English ☐Other _____

Nickname_____ Likes to be called _____ Religion _____

Age at retirement_____ How did the applicant adjust to retirement?_____

Is the applicant a veteran? ☐Yes ☐No Education: ☐8th grade ☐High school ☐College ☐Other _____

Marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed If widowed, how did he/she adjust? _____

What have we not asked you that you that you think we need to know?
Financial Responsibility (Required)

Applicant _____ **Caregiver** _____

Financial Responsibility (Required)

I, (please print)_____ understand that I am responsible for all
Caregiver/responsible party
Fees and charges incurred by (please print) _____ at Regal Adult Day Services.
Participant

Sign Here: **#1 Signature** **Date**

_____ _____

Billing Address if different than caregiver's address:

_____
City/State/Zip
_____

Authorization for Emergency Care (Required)

I understand that Regal Adult Day Services is a social agency and that no medical services are available at Regal Adult Day Services. I hereby authorize Regal Adult Day Services to have the above named participant transported by ambulance for medical treatment in the event of an emergency. I agree to pay for all costs incurred. I also give permission for Regal Adult Day Services staff to provide emergency medical personnel with any information which will assist them in the treatment of the emergency.

Sign Here: **#2 Signature** **Date**

_____ _____
Caregiver/responsible party

Notice and agreement (Required)

The caregiver shall hold Regal Adult Day Services harmless against all loses, damages, accidents or injuries to person or property of any participant or family member, guest, invitee or servant of the participant or caregiver caused by or resulting from or in connection with his/her/their use or occupancy of the Regal Adult Day Services premises or things in or about the Regal Adult Day Services premises including travel to or from Regal.

Sign Here: **#3 Signature** **Date**

_____ _____
Caregiver/responsible party

Photo/Media/Artwork/Release (Optional)

I give Regal Adult Day Services unlimited permission to use, publish and republish in the furtherance of its work, reproductions of my likeness by photographic or electronic media means (such as television, Internet) for advertising purposes, with the use of my first name. I give my permission for my voice to be recorded and my art work, or a reproduction to be used without compensation to me or to my family.

Please note: Failure to agree to Photo/Media/Artwork release will not affect your family member's eligibility for the program.

Sign Here: **Signature** **Date**

_____ _____
Participant

And/or: **#4 Signature** **Date**

_____ _____

Intentionally left blank

CURRENT MEDICATIONS
Please list ALL medications being taken
List both PRESCRIPTION and NON-PRESCRIPTION, over the counter drugs, herbal and Natural supplements, whether they will be taken at the center or not.
In an emergency, EMTs will ask about ALL medications being taken.

Applicant Name: _____ Date _____

Date	Medication Name	Dose	Frequency	Reason for taking	Will take at center?
(Example) 4/14/13	(Example) Respirdal	(Example) 0.5 mg	(Example) 1 tab each day	(Example) Anxiety	(Example) Yes/No

Physician/Nurse Practitioner:_____

Physician's Statement Form

Fax completed form to 219-413-5245

Date:_____

To: _____

MD fax:_____

Your Patient's (Name):_____

(Address): _____

Is making application to attend Regal Adult Day Services program. Please complete the following and return to Regal Adult Day Services, 3924-26 Main St., Ste. 102, East Chicago, IN 46312, or FAX to 219-413-5245.

Your patient cannot be enrolled until this form is returned to us:

Primary diagnosis: _____

Secondary diagnosis: _____
(use back if necessary)

Date of last examination_____

I certify that _____ is free from any communicable diseases and is also able to participate in an adult day program with the following limitations:

Physical limitations: _____

Dietary limitations: _____

Allergies: _____

Physician's Name: _____

Address:_____

Phone: _____

Date: _____ Signature: _____