St. Joseph's Home
950 Linden Street, Ogdensburg, New York 13669
(315) 393-3780
Attention: Melissa Lalonde

Social Adult Day Program

Application

St. Joseph's Home
Social Adult Day Program
950 Linden Street
Ogdensburg, NY 13669
315-393-3780

Participation Agreement

As a participant in the Home's Social Adult Day Program, I _____
(name of participant) or my responsible family member agrees to the following:

1. To schedule with the Home's staff by Friday of the prior week the planned attendance of the participant for the subsequent week, with said schedule dependent upon staff resources or other extenuating circumstances as determined by the Home.

2. That participation in the program may be terminated by the client with at least one business day's notice to the Home and the Home may terminate the program or participant's participation with one week's notice unless extenuating circumstances as determined by the Home necessitate shorter termination.

3. Hold the Home harmless for any injury which occurs during the course of participation in the program.

4. Permit the taking and use of a photograph or videotape in conjunction with the activities while in attendance at the program.

5. Pay a $150 deposit of which $100 will be applied toward any remaining balance of program fees. Program fees shall be charged monthly at a rate of $40/day including lunch.

6. The participant's family remains responsible for transportation of the participant to and from the program.

7. The above terms and conditions may be modified by mutual agreement of both parties, but only if put in writing and signed by both parties.

AGREED TO BY:

_____ _____
Participant or Participant Representative Date

Application

Date: _____ Referral: _____

Name: _____ DOB: _____

Current Address: _____

_____

Religion: _____ Telephone: _____

Living Alone? Yes _____ No _____

Spouse/Significant Other: _____

SSN: _____

Contact Person/Caregiver: _____

Contact Person/ Caregiver Phone #: _____

In Case of Emergency Notify:

Name: _____

Address: _____

_____

Relationship: _____

Work Phone: _____ Home Phone: _____

Name: _____

Address: _____

_____

Relationship: _____

Work Phone: _____ Home Phone: _____

Assessment

Physician's Name: _____ Phone #: _____

Address: _____

Medications	Dosage	Frequency

Allergies: _____

Diabetes: _____ Blood Type: _____

Normal Blood Pressure: _____ Glasses: _____

Continent: _____ Allergies: _____

Does the participant exhibit any of the following behaviors? Indicate frequency.

_____ generally content and cooperative
_____ confused and/or disoriented
_____ anxious or restless
_____ expressed or cries frequently
_____ paranoid
_____ wanders
_____ some memory loss
_____ significant memory loss
_____ history of assaultive behavior
_____ history of alcohol or drug abuse
_____ socially inappropriate behavior, please describe: _____
_____

Are there certain times of the day, or certain daily events that seem to affect the person's mood?

ADVANCE DIRECTIVES:
Health Care Proxy _____ DNR/CPR _____ Agents _____

SENSORY:

_____ good vision (with or without corrective lenses)
_____ difficulty reading or with other fine visual skills
_____ poor vision
_____ blind _____ legally blind, or _____ nearly blind
_____ cataracts, glasses
_____ hearing adequate Hearing aid? Yes or No
_____ somewhat hard of hearing
_____ profoundly hard of hearing
_____ deaf

COMMUNICATION:

_____ speech clear and distinct
_____ speech somewhat impaired
_____ speech profoundly impaired
_____ speak foreign language (specify) _____

SOCIAL PATTERNS:

_____ daily contact with relatives or close friends
_____ daily animal companion/presence
_____ involved in group activities
_____ usually attends church, temple, synagogue
_____ finds strength in faith

HOW WOULD YOU DESCRIBE YOURSELF:

_____ at ease with others
_____ at ease with planned or structured activities
_____ at ease with self initiated activities
_____ establishes own goals
_____ active with community friends or neighbors
_____ able to adjust easily to change in routine
_____ none of the above

LIST HOBBIES OR INTERESTS:

_____

_____

_____

How much help does the resident need with the following activities?

_____ Taking Medications _____ Eating

_____ Reading _____ Walking

_____ Toileting _____ Other

History of smoking or alcohol? If yes, how much?

Smoking _____
Alcohol _____
When did you quit? Smoking _____ Alcohol _____

LIKES & DISLIKES

Afraid of animals	Yes or No	
Games	Yes or No	What games? _____
Socialization	Yes or No	
Walking	Yes or No	
Exercise	Yes or No	
Favorite beverage	_____	
Favorite food	_____	
Musical entertainment	Yes or No	

Church: Mass (6 times/week) or Protestant (Wednesdays) _____
Coffee, Tea, Hot Chocolate? _____

Additional information that might be helpful to the Social Adult Day staff:

_____

_____

Signature of Applicant: _____ Date: _____

St. Joseph's Home
Social Day Program
950 Linden Street
Ogdensburg, NY 13669
315-393-3780

HOSPITAL TRANSPORT PERMISSION FORM

I, _____ do hereby give permission to St. Joseph's Home, Ogdensburg, New York, Social Day Program to transport my _____ to the hospital in the event he/she needs medical attention while at the Social Day Program.

Signature _____ Date _____

Please Print Name _____

Address _____

Telephone # _____ Work _____

Witness _____ Date _____

Please Print Name _____