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

Social Adult Day Care Program

Application

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Social Adult Day Care Program
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Ogdensburg, NY 13669
315-393-3780

Participation Agreement

As a participation in the Home's Social Adult Day Care 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 $50/day beginning January 1, 2016, which includes lunch. A day shall be defined as four (4) or more hours between 10 AM and 4 PM.

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: _____
_____, New York _____

Religion: _____ Telephone #: _____

Living Alone? Yes ___ No ___

Spouse/Significant Other:_____

SSN#: _____Medicare #: _____

Other Insurance: _____

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: _____
Normal Blood Pressure: _____
Continent: _____Glasses: _____

Diet Restrictions: _____ 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 INTEREST:

_____
_____
_____

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

_____Taking Medications
_____ Reading
_____ Toileting
_____ Eating
_____ Walking
_____ Other

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
Musical entertainment	Yes or No

Would you like to attend Church: Mass (6xWk) or Protestant (Weds.) Yes or No

Favorite beverage _____

Favorite food _____

Coffee, Tea, Hot Chocolate _____

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

_____

_____

Signature of Applicant _____

Date: _____

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HOSPITAL TRANSPORT PERMISSION FORM

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

Signature _____ Date _____

Please Print Name _____
Address _____
Telephone # _____ Work _____

Witness _____ Date _____

Please Print Name _____

The MOLST form (Pink Form) must be filled out with your physician and returned to Melissa Lalonde at St. Joseph's Home prior to initial attendance of the program.