



**PARTICIPANT REGISTRATION INFORMATION**

Participant name:		
Birthdate:		Age:
Social security number:		
Address:		
City:	State:	zip:
Home phone:		Mobile phone:
Email:		
Primary language:		
Marital status:		Living with:

Primary Caregiver's name:		Relationship:	
Address:	City:	State:	Zip:
Home phone:	Cell:	Work phone:	
Email address:			

Emergency Contact 1:		Relationship:	
Home Phone:		Mobile Phone:	
Email:		Work Phone:	
Emergency Contact 2:		Relationship:	
Home Phone:		Mobile Phone:	
Email:		Work Phone:	

**Emergency Care Authorization**

In the event of an emergency, I give permission for \_\_\_\_\_ to be transported to the nearest emergency room or to my preferred hospital (depending on the nature of the emergency). I understand that I am responsible for all the charges resulting from the emergency care, including ambulance or rescue squad charges. I also give permission for EADS staff to provide emergency medical personnel with any information that will assist them in treatment of the emergency.

Preferred Hospital: \_\_\_\_\_

Caregiver's signature: \_\_\_\_\_ date: \_\_\_\_\_

Participant name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Physician Information**

Participant's physician:	Specialty:
Address:	Phone:

Diagnoses:
Allergies:
Dietary restrictions:

**Advanced Directives Notification**

- My family member does not require a Power of Attorney (POA), may make his/her own medical or other decisions, and my sign for himself/herself legally.
- My family member has a POA or legal guardian.  
name / number: \_\_\_\_\_
- My family member has an advance directive and **I will provide Evergreen ADS with an original copy.**
- My family member does not have an advance directive and would like information.
- My family member does not want an advance directive.
- My family member has a **DNR. I will provide Evergreen Adult Day Services with an original copy.**

Persons authorized to pick up participant from Evergreen Adult Days Services: (names, phone)

Name:	Email:
Home Phone:	Mobile Phone:

Name:	Relationship:
Home Phone:	Mobile Phone:

Other Information:
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Participant name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Enrollment Date: \_\_\_\_\_

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**Attendance Plan:**

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**Monthly plans for Pre-selected weekly schedule** (please initial choice).

- \_\_\_ \$ 1512 Basic care 5-days per week      \_\_\_ \$ 1701 Enhanced care 5-days per week
- \_\_\_ \$ 1224 Basic care 4-days per week      \_\_\_ \$ 1377 Enhanced care 4-days per week
- \_\_\_ \$ 998 Basic care 3-days per week      \_\_\_ \$ 1112 Enhanced care 3-days per week
- \_\_\_ \$ 684 Basic care 2-days per week      \_\_\_ \$ 769 Enhanced care 2 days per week

- Payment for monthly plans are **due the first weekday** of every month. \_\_\_\_\_ (initial)
- Please select the days of week participant will attend.

Monday	Tuesday	Wednesday	Thursday	Friday
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**Scheduled as needed.**

\_\_\_ \$ 80 per day -Basic Level of care    \_\_\_ \$ 90 per day -Enhanced Level of care

- Each day is scheduled as needed. Payments for as-needed days are due at the time of scheduling.

**Scheduled ancillary services.**

- \_\_\_ \$ 22 full baths with shampoo & shave
- \_\_\_ \$ 15 daily personal care or partial baths
- \_\_\_ \$ 22 Appliance change or complex wound care

- Each service is scheduled as needed. Payment for ancillary services are due at the time of the scheduling or the date of service, whichever comes first.

**Please notify the Center if the Participant will be absent on a scheduled day. A two-week absence without notification will result in the Participant being discharged.**

Participant name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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**Funding Source:**

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- Evergreen accepts private pay. Forms of payment may be check or credit card. Cash is accepted for transactions of \$50 or less.
- Detailed Monthly invoice with level of service, number of days attended per month and any ancillary services used will be provided upon request at the end of each month which may be used for Veterans Administration, Long Term Care Insurance or other re-imbusement programs.

\_\_\_ I will pay by check by the first weekday of the month for scheduled services.

\_\_\_ Charge my credit card on file for scheduled monthly services

Name as it appears on Card: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ exp date: \_\_\_\_\_ CVV code: \_\_\_\_\_

Signature: \_\_\_\_\_

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**Receipt and Acknowledgement of Program Policies**

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I have received my copy of Evergreen Adult Day Services' Program Policies dated March 2017. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures contained within.

I understand the rates and schedule of payment policy as stated above. I understand failure to pay this charge is grounds for termination of services. By signing below, I acknowledge that I agree to pay for services as charged.

We, Caregiver/Participant, agree to comply with the rules and regulations stated in this agreement and the Caregiver/Participant Handbook.

\_\_\_\_\_  
Signature Responsible Party

\_\_\_\_\_  
DATE:

\_\_\_\_\_  
Signature of Director/Staff

\_\_\_\_\_  
DATE:

Participant name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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### CONFIDENTIALITY

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All information in the participants file will be used only for emergency needs and for staff to aid in the proper care of the participant.

Only information needed to assist in the care of the participant will be released.

All information will be kept confidential and shared with no other agency or organization without written consent from participant or guardian.

\_\_\_\_\_  
Signature Participant/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Director/Staff

\_\_\_\_\_  
DATE:

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### RELEASE PROTECTED INFORMATION FORM

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I authorize *Evergreen Adult Day Services* to disclose the participants protected health information to his/her healthcare providers or emergency services when deemed necessary to provide appropriate treatment and to maintain the participant's well-being.

\_\_\_\_\_  
Signature Participant/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Director/Staff

\_\_\_\_\_  
DATE:

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### RECEIVE PROTECTED INFORMATION FORM

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I authorize *Evergreen Adult Day Services* to receive any medical information from the participant's healthcare provider(MD/NP/PA) when deemed necessary to provide appropriate treatment and to maintain the participant's health and wellbeing.

\_\_\_\_\_  
Signature Participant/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Director/Staff

\_\_\_\_\_  
DATE:

Participant name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**AUTHORIZATION FOR USE OR DISCLOSURE OF PARTICIPANT  
PHOTOGRAPHIC AND/OR VIDEO IMAGES**

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**Authorization:**

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Evergreen Adult Day Services Center. I understand that information disclosed pursuant to this authorization such as photographs, video and/or interview content may disclose the fact that I am or have been a member of Evergreen Adult Day Services.

**Purpose:**

The photographic/video images and/or testimonial may be used for publicity, educational, marketing, advertising and fundraising purposes through internal publications, external publication, radio, television, video or internet. (I have crossed out any purposes or media format I do not wish included.)

**Revocability:**

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 10 years from date signed.

I understand that Evergreen Adult Day Services Center cannot condition treatment on whether I sign this authorization.

\_\_\_\_\_  
Signature Participant/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Director/Staff

\_\_\_\_\_  
Date