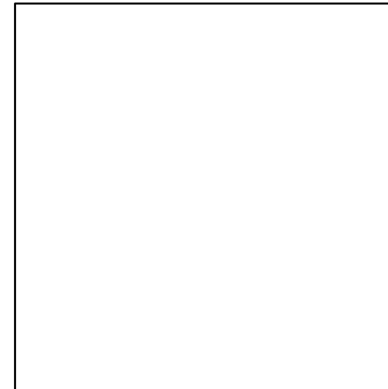
Evergreen
Adult Day Services

3434 Kildaire Farm Road, #129
Cary, NC 27518
(919) 238-4738
www.EvergreenAdultDayServices.net

PARTICIPANT REGISTRATION INFORMATION

Participant name:		
Birthdate:		Age:
Social security number:		
Address:		
City:	State:	zip:
Home phone:	Mobile phone:	
Email:		
Primary language:	Religious affiliation:	
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: ____________

☐ **Please provide copies of all health insurance cards front and back: Medicare, Medicaid, Private, etc.**

Participant name: ____ Date of Birth: _______________

Cognitive, Social & Functional Assessment 2020

Instrumental Activities of Daily Living: Can the participant carry out the following tasks without help?

1. Prepare Meals ☐ YES ☐ NO Comment:______________________.
2. Shop for personal items ☐ YES ☐ NO :______________________.
3. Manage own Medication. ☐ YES ☐ NO :______________________.
4. Manage own Money (pay bills) ☐ YES ☐ NO :______________________.
5. Use telephone ☐ YES ☐ NO :______________________.
6. Do heavy housework. ☐ YES ☐ NO :______________________.
7. Do light cleaning ☐ YES ☐ N :______________________.
8. Transportation ☐ YES ☐ NO :______________________.

Activities of Daily Living: Can the participant carry out the following tasks without help?

1. Eat ☐ YES ☐ NO Comment:______________________.
2. Get Dressed ☐ YES ☐ NO :______________________.
3. Bathe self ☐ YES ☐ NO :______________________.
4. Use the toilet ☐ YES ☐ NO :______________________.
5. Transfer into/out of bed/chair ☐ YES ☐ NO :______________________.
6. Do heavy housework. ☐ YES ☐ NO :______________________.
7. Ambulate (Walk or move around the house without anyone's help) ☐ YES ☐ NO :______________________.

Cognitive Issues: Does the participant exhibit any of the following thoughts/behaviors?

1. Wandering / Exit seeking ☐ YES ☐ NO Comment:______________________.
2. Confusion ☐ YES ☐ NO :______________________.
3. Fear/Anxiety ☐ YES ☐ NO :______________________.
4. Other: _____________ ☐ YES ☐ NO :______________________.

Social Support Status: List all members of the household including pets______________________

____

____

List social, cultural and religious considerations______________________________________

____

____

Medical Care Needs: Does the participant need to take medication or skilled nursing tasks during the day (examples: frequent BP reading, insulin, oral meds, appliance checks or bandage changes)

1. Medication ☐ YES ☐ NO Comment:______________________.
2. Wound or appliance tasks ☐ YES ☐ NO :______________________.
3. Other: _______________ ☐ YES ☐ NO :______________________.

Participant name: ____ Date of Birth: _______________

Healthcare Profile

Physician Information

Participant's physician:	Specialty:
Address:	Phone : Fax:

Diagnoses:
Allergies:
Dietary restrictions:

Advanced Directives Notification

☐ My family member does not require a Power if 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 drop off and pick up the participant from Evergreen Adult Days Services:

Name:	Email:
Home Phone:	Mobile Phone:

Name:	Email:
Home Phone:	Mobile Phone:

Other Information:

Participant name: ____ Date of Birth: _______________

CONFIDENTIALITY

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:

RELEASE PROTECTED INFORMATION FORM

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:

RECEIVE PROTECTED INFORMATION FORM

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: _______________

Receipt and Acknowledgement of Program Policies

I have received my copy of Evergreen Adult Day Services' Program Policies. 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 Participant/Guardian Date

____ _______________
Signature of Director/Staff DATE:

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

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Evergreen Adult Day 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 Center.
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 Center cannot condition treatment on whether I sign this authorization.

____ _______________
Signature Participant/Guardian Date

____ _______________
Signature of Director/Staff DATE: