Bon Homie, Ltd. Adult Daily Living Center Enrollment Agreement

Name____Admission Date__________________
Address_______________________________________Township____________________________
Phone #_______________________________________Social Security #______________________
Age____Date of Birth_________________________
Height____Weight_______________________________
Color of Hair__________________________________Race_________________________________
Male/Female___________________________________

Name of Caregiver_____________________________Home #_____________________________
Relationship__________________________________Work #______________________________
Caregiver's Address____

Physician's Name______________________________Address____________________________
Phone #_______________________________________

Medical Background:

Client diagnosis, disabilities, illnesses or conditions_________________________________
____
____
____
Limitations, treatments or special care required_____________________________________
____
____
____
Allergies:Drug________________________________Food_______________________________
Type of diet? Regular, diabetic, other:____________________Dentures YES or NO
Sleep Patterns_________________________________Exercise Patterns_____________________

Physical Activities of daily living: Please circle below.

Eating	Self Care	With Assistance	Total Care
Bathing	Self Care	With Assistance	Total Care
Dressing	Self Care	With Assistance	Total Care
Toileting	Self Care	With Assistance	Total Care
Does the client wear an incontinent pad?		Yes	No
Mobility	Self Care	With Assistance	Total Care

Transferring from wheelchair to commode:

	Self Transfer	With Assistance	Total Care
Hearing	Normal	Slight difficulty	Moderate-Severe

Does the individual wear a hearing aide?___________yes or _________no
If yes, does the client wear one in his left ear, right ear or both?______________________________

Sight	Normal	Slight difficulty	Moderate-Severe

Does the individual wear glasses?_________yes or _________no

Speech	Normal	Slight difficulty	Moderate-Severe
Communication	Clear	Difficulty understanding	Difficulty expressing

Intellectual Functioning (Please Circle)

Able to make decisions	Always	Sometimes	Never
Able to plan	Always	Sometimes	Never
Distant memory accurate	Always	Sometimes	Never
Recent memory accurate	Always	Sometimes	Never
Knows time/date	Always	Sometimes	Never
Knows others	Always	Sometimes	Never
Knows place	Always	Sometimes	Never
Knows self	Always	Sometimes	Never
Knows danger	Always	Sometimes	Never

Mental Emotional Status (Please mark appropriate lines)

____Alert	____Occasionally Confused	____Confused	____Wanders
____Social/Friendly	____Lonely	____Anxious, Worried	____Fearful
____Passive, Withdrawn	____Irritable	____Agitated	____Easily Upset
____Depressed	____Angry	____Loss of interests	____Paces

Social Background

Previous Occupation____
Religious Affiliation____
Children (Names/Ages)____
Current Activities/Interests____
Former Activities/Interests____
Food: Like____Dislikes_____________________________

Approximate Date Client Experienced The Following:

______________________________Death of Spouse/Significant other
______________________________Major illness or injury
______________________________Marriage/Remarriage
______________________________Change in Residence
______________________________Change in Household Members
______________________________Change in Financial Status
______________________________Retirement

Please list all services currently received, include frequency and agency involved

Services	Agency	Frequency
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

The family of ________________________________, who began attending our center on _________________________________ has received copies of the following forms:

1. Enrollment Agreement
2. Nondiscrimination in Services
3. Clients Rights
4. Civil Rights Policies
5. Billing Policy
6. Discharge Policy
7. Grievance Procedures
8. Ombudsman
9. HIPAA Policy

We have received copies of all forms listed above.

______________________________ ______________
Signature of Caregiver Date

______________________________ ______________
Signature of Director Date

Please indicate if your family member can be given non-prescription pain relievers in the appropriate doses to relieve minor aches or pains.

Please complete the following entries:

Client's name: _____________________________________

Is permitted to be given: _______Tylenol _______Ibuprofen _______Either

Is not permitted to be given pain relievers: ______________

Date_________________________________ Caregiver's Signature__________________________

Client Rights

I have read or have had explained to me my rights while I'm in attendance at Bon Homie, Ltd. Adult Day Services Center. I understand that I may request further clarification of my rights from center staff if I so desire.

My signature acknowledges that I have received a copy of the Client Rights.

Client's Signature_____________________________ **Date**_________________________________
Caregivers Signature___________________________ **Date**_________________________________
Relationship___________________________________

Emergency Medical Care Authorization

While visiting and/or participating in the Adult Day Services Center, I hereby authorize the following procedures in case of medical emergency and take full responsibility for any expenses incurred.

Arrange for emergency transportation.
Contact family or person responsible for participant.
Contact personal/attending physician.

Hospital Preference____________________________________Phone________________________________
(We cannot guarantee that your loved one will be taken to your hospital of choice but we will inform 911.)
Family or person responsible for participant
Name____Phone________________________(Home)
Relationship____Phone________________________(Work)
Name____Phone________________________(Home)
Relationship____Phone________________________(Work)

Weather and Emergency Closing Contact Information

Responsible Party_____________________________________Phone________________________(Home)
Phone________________________(Work)
Back-Up #1 _____________________________________Phone________________________Home)
Phone________________________(Work)

Back-Up #2 _____________________________________Phone________________________(Home)
Phone________________________(Work)

If Van Transported
Does participant carry a key? YES___________No____________
If Yes, Can they be left alone at home? YES___________No____________

How did you find out about our services?_______________________________

I hereby consent to receive the services of the Bon Homie, Ltd. Adult Day Services Center and authorize the center to obtain the necessary medical/social information from my physician or other health care professionals. Final acceptance into the program is contingent upon receipt of all information and the multi-disciplinary assessment provided by the center.

Signature of Applicant/Client___________________________________Date_________________________
Signature of person responsible for payment to the Bon Homie, Ltd. Adult Day Services Center for services rendered.____
Name____Date_________________________
Address____
Director____Date_________________________

Photograph and Voice Release

Consent and permission is hereby granted to the Bon Homie, Ltd. Adult Day Services Center agents, employees and to any person, firm or organization that the center may designate or authorize to take photographs, motion pictures, videos, and/or the recording of my voice: I waive all claims for any compensation for such use or for damages.

This consent includes the use of such pictures, photographs, films, or voice with or without my name and biographical data concerning me by the center of anyone else on its behalf, without limitation as to time or frequency of use, for any or all of the following purposes:

1. Newspaper releases.
2. Release to other media of communication.
3. Educational, instructional, legal, advertising or teaching purposes.
4. Research activities.
5. Publicity or fund raising.
6. Brochure layout.

(Please Note: The signer may strike out any of the foregoing purposes not desired.)

Signature of person photographed/voice recorded:________________________________
Print name of above signature:____
Signature of responsible party/relationship:_____________________________________

Where better days blossom.

Date: December 15, 2010

Subject: Nondiscrimination in Services

To: Clients

From: Ann Short, Director

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, age, sex, national origin (including limited English proficiency), age or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and/or their guardian) who believes they have been discriminated against may file a complaint of discrimination with:

Bon Homie, Ltd.
470 North Lewis Road
Limerick, PA 19468

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Commonwealth of Pennsylvania
DPW-Bureau of Equal Opportunity
Southeast Regional Office
Suite 5034 – 5th Floor
801 Market Street
Philadelphia, PA 19107

U.S. Department of Health & Human Services
Office of Civil Rights
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, Pennsylvania 19106-3499

PA Human Relations Commission
110 North 8th Street
Suite 501
Philadelphia, Pennsylvania 19107

____
Caregiver/Client Signature

____
Date

____
Staff Signature

____
Date

470 North Lewis Road, Limerick PA 19468 • 610-792-8800 • Fax 610-792-8820 • www.bonhomieadc.com