Meals On Wheels Atlanta
The Vivian T. Minor Adult Day Health Center

Pre-Admission Information

Date: _____

Name: _____ D.O.B. _____

Address: _____ City/State _____ Zip _____

County: _____

Telephone #: _____

Social Security #: _____ Medicare #: _____

Private Insurance: _____ Medicaid #: _____

Monthly Household Income: _____

Hospital Preference: _____

Former Occupation: _____

Hobbies/Special Interests: _____

Is Applicant Continent? _____ If not circle appropriately: Bowel Bladder

Physician's Name/Address/Phone Number (please list all)

_____

_____

Date of Applicants last doctor's visit _____

Date of last hospitalization: _____

Reason for hospitalization: _____

Date of surgical procedure(s) _____

Does Applicant live alone? _____ If not, with whom? _____

In case of an emergency we must have two local contacts on file:

1) Name _____ Relationship _____
   Telephone #(w) _____ (h) _____
2) Name _____ Relationship _____
   Telephone #(w) _____ (h) _____

Reason for adult day program needs: _____

All of the above information is true to the best of my knowledge.

Signature: _____ Telephone #: _____
(Person completing application)

By signing this document does not guarantee acceptance into Adult Day Program.

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Adult Day Health File Request Procedure

- Eligibility/Beneficiary Requirement
- Physician Evaluation
- Pre-Admission Information
- Medical Alert
- Income Verification
- Payment Contract
- ADA Disclosure
- Waiver
- Monthly Summary Report
- Monthly Activity Report
- Monthly Activity Participation
- Vital Signs
- Monthly Member Service Record/Progress Note
- Client's Rights
- Client's Responsibilities
- Advance Directive Check List
- Client Emergency information
- Field Trip Permission
- DON-R/NSI
- CCSP Service Order*
- Care Plan
- File Request Procedures
- Photo Release Form
- Photo

*CCSP Service Order only for clients on CCSP

Client's Name: _____

I understand that the fore mention items are needed for the recipient to receive services at Meals On Wheels Atlanta Adult Day Health. I am able to make a written request of a copy of recipient's file at any time. Requested files will be available within 14 days of written request.

_____ _____

Responsible Party Date

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Vivian T. Minor Adult Day Health Photo Release Form

I hereby consent to and authorize the use and reproduction of any and all photographs and television images which have been taken of the recipient receiving ADH/Meals On Wheels Atlanta services. I understand I will receive no remuneration for allowing pictures to be taken and the use of said photographs is at the discretion of Meals On Wheels Atlanta. It is also agreed that the recipient receiving ADH/Meals On Wheels Atlanta services name may accompany photographs or televisions spots when deemed appropriate by Meals On Wheels Atlanta.

Clients Name:_____

_____ _____

Responsible Party Date

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Medical Alert

Participant Name: _____

Diagnosis: _____

_____

_____

Medication	Dosage	Reason

Contact Immediately:

_____

_____

_____

_____

Allergies:

_____

_____

Physician's Signature _____ Date: _____

Update: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Initials: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Meals On Wheels Atlanta
The Vivian T. Minor Adult Day Health Center

Physician's Evaluation Form

Name: _____ D.O.B. _____

Address:_____City/State_____ Zip _____

Diagnosis, chronic, illnesses and impairments:_____

_____

B.P._____ Pulse: _____ Weight: _____

_____

_____

_____

Allergies (Food or Drug):_____

TB Test Results:_____

Diet (Please circle appropriate diet for client)

Regular Low Cholesterol No Added Salt No Concentrated Sweets

What would be emphasized in the program for your patient and their condition: Please check all that apply:

_____Flexibility Exercise (i.e. Chair Stretching)
_____Low Impact Aerobic Activities (i.e. Weight Training)
_____ Resistance training (i.e. Weight Training)
_____ Swimming/Water Exercises
_____Physical therapy
_____Occupational therapy
_____Speech Therapy

Special Considerations/Precautions/Comments:_____

_____

I hereby certify that the above day service plan is medically necessary and is approved by me:

Physician's Signature _____ Date:_____

Physician's Address: _____

Physician's Phone Number:_____

Meals On Wheels Atlanta
The Vivian T. Minor Adult Day Health Center

Client Emergency Information Form

Client's Name:_____

Medicaid Number:_____

Home Address:_____

Home Telephone:_____

_____

Emergency Transportation for Treatment:_____

Advance Directive Information:_____

_____

Medical Information
Physician's Name:
Physician's Telephone:
Client's Hospital Preference:
Known Medication Allergies/Pertinent Medical Information:

Client Representative or Family Members/Emergency Contacts:

Name:_____ Relationship:_____

Telephone (w): _____ (h):_____

Review Date: _____ Date_____

Name:_____ Relationship:_____

Telephone (w): _____ (h):_____

Review Date: _____ Date_____

Please read the following statements. After reading the statements, please check **ONE** of the following statements:

_____ I have executed an Advance Directive and will provide a copy to the CCSP provider agency providing services. I understand that the staff of:_____ _____ will not be able to follow the terms of my Advance Directive until I provide a copy of it to the staff.

_____ I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.

_____ I have not executed an Advance Directive but would like to obtain additional information about Advance Directives.

Client's Signature: _____ Date:_____

Witness' Signature: _____ Date:_____

Meals On Wheels Atlanta
The Vivian T. Minor Adult Day Health Center

Client Responsibilities

Client responsibilities recognized by Meals On Wheels Atlanta (MOWA)/Adult Day Health (ADH)

1. The responsibility to notify MOWA/ADH of any changes in care needs.
2. The responsibility to treat MOWA staff in a courteous and respectful manner as well as cooperate with and respect the rights of caregivers providing care.
3. The responsibility to be as accurate as possible when providing information on health history and personal care needs.
4. The responsibility to participate actively in decisions regarding individual health care and service/care plan
5. The responsibility to comply with agreed upon care plans.
6. The responsibility to notify the client's physician, MOWA and /or caregiver of any change in one's condition.
7. The responsibility to maintain a safe home environment or to inform MOWA of the presence of any safety hazard in the home.
8. The responsibility to be available to provider staff at times services are scheduled to be rendered.
9. The responsibility to pay any cost share liability, if applicable
10. The responsibility to be informed of the reason for discharge and the procedure for appealing that decision.
11. The responsibility to a clean and safe environment while at the program facility.

Caregiver's Signature: _____ Date:_____

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Client Rights – Adult Day Health

Client's rights recognized by Meals On Wheels Atlanta/ADH

1. The right of access to accurate and easy-to-understand information.
2. The right to be treated with respect and to maintain one's dignity and individuality.
3. The right to voice grievances and complaints regarding treatment or care that is furnished or not furnished, with or without fear of retaliation, discrimination coercion or reprisal.
4. The right to a choice of approved service provider(s).
5. The right to accept or refuse services.
6. The right to be informed of and participate in preparing the care plan and any changes in the plan.
7. The right to be advised in advance of the agencies who will furnish care and the frequency and duration of visits ordered.
8. The right to confidential treatment of all information, including information I the client record.
9. The right to receive services in accordance with the current care plan.
10. The right to be informed of the name, business telephone number and business address of the person supervising the services and how to contact that person.
11. The right to have the property and residence treated with respect.
12. The right to be fully and promptly informed of any cost share liability and the consequences if and cost share is not paid.
13. The right to review client's record on request.
14. The right to receive adequate and appropriate care and services.
15. The right to be free from mental, verbal, sexual and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily function of living.
16. The right to be free from chemical or physical restraints.
17. The right to be informed of the reason for discharge and the procedure for appealing the decision.
18. The right to a clean and safe environment while at the facility.

Signature: _____ Date:_____

Meals On Wheels Atlanta
The Vivian T. Minor Adult Day Health Center

Adult Day Health Income Verification

Client's Name:_____ D.O.B. _____

Race (Check one)

- ☐ Black/African American
- ☐ White
- ☐ Hispanic or Latino
- ☐ American Indian or Alaskan
- ☐ Other

Client's Gender ☐ male ☐ female

Fulton county residents yes ☐ no ☐

If no, what county does the client reside?

_____

Income Documents; (Please include a copy with this document)

☐ Source (Please check all that apply)	☐ Monthly	☐ Yearly
☐ SSI/Pension		
☐ Wages, Salary, Tip, Commission		
☐ Unemployment		
☐ Child Support/Spousal Support		
☐ Interest, dividends, net rental income, income from estates or trusts		
☐ Supplementary Income (Public Assistance)		
☐ Other or Wage Inquiry from GA Dept. of Labor		

I hereby certify that the above information is complete and accurate to the best of my knowledge. I understand that false statements on this document could jeopardize the services I receive at/through Meals On Wheels Atlanta and may be punishable under the law.

POA/Caregiver:_____ Date:_____

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Vivian T. Minor Adult Day Health Program Waiver

Vivian T. Minor Adult Day Health Program provides the minimum nursing care for clients as needed and/or as requested by administrator. This nursing care includes checking Blood Pressure, Blood Sugar, Respiration, Heart Rate and/or Temperature. Nurse will also check for bruising under garments if probable cause (pain, etc.). Clients will be provided assistance with the restroom and feeding as needed under the direction of Meals On Wheels Atlanta/ADH staff. Clients may be subject to exercise which may include short distant walking and minimum range of motion. ADH Clients may go on trips such as site-seeing, luncheons, concerts and various indoor and outdoor events. ADH will provide caregiver with a calendar or a letter of any outdoor event that the client may be participating in that month.

I understand the above services and give consent for the client listed below to participate in all indoor and outdoor activity MOWA/ADH provides and I hereby assume all of the risks of client listed below participating and or volunteering in activities or events while client is in the care of MOWA/ADH.

Client's name:_____ D.O.B. _____

POA/Caregiver:_____ Date:_____

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Field Trip Permission

(Name)_____ has my permission to participate in field trips and other activities, in or away from the Health.

_____ _____

POA/Caregiver signature Date

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Adult Day Health
Eligibility/Beneficiary Requirement

_____ *60 year old and above
_____ **Resident of Atlanta
_____ Alzheimer, Dementia or Memory Impairment

The Client listed below is eligible for services at Vivian T. Minor Adult Day Health

Clients Name:_____

MOWA/ADH Staff Signature:_____ Date:_____

* Resident 50 and above will be considered ad Administrator's discretion, based on diagnosis.
** Clients that are not residents of Atlanta will be considered at Administrator's discretion, based on location and transportation to the center.

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Vivian T. Minor Adult Day Health Payment Contract

Client's Name:_____ D.O.B._____

***Payment** (Check One)

☐ Daily Payment
☐ Monthly Payment
☐ CCSP

You have chosen to pay the daily rate, based on the assessment of _____'s income. You will be charged $_____ a day. Payments are due weekly each Friday.

You have chosen to pay the monthly rate, based on the assessment of _____'s income. You will be charged $_____ a month. Payments are due on the 5th of each month.

CCSP Cost Share is $_____ a month. Payments are due on the 5th of each month.

The above client has been deemed eligible for service at the price stated. Non-payment for services after 7 business days can result in client not being able to participate in Vivian T. Minor Adult Day Health program, at the Administrator's discretion. CCSP Clients monthly charge (cost share) is determined by CCSP and will be due on the5th of each month.

POA/Caregiver Name:_____ Date:_____

MOWA/ADH Staff Signature:_____ Date:_____

*payments assist with the operation of the program, which includes staffing, supplies, client's meals, activities, activity supplies and transportation.

Meals On Wheels Atlanta
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Release, Waiver of Liability and Covenant Not To Sue

(Read Carefully Before Signing)

The undersigned ("Caregiver") hereby acknowledges that participation in Adult Day Health's programmatic and recreational activities may involve a risk of physical injury and assumes all such risks. The undersigned hereby agrees that for the sole consideration of Meals On Wheels Atlanta (the "Institution") allowing the undersigned to participate in voluntary recreational programmatic or recreational activities in connection there with, and making available to the undersigned for his/her use while participating in such programs or activities, certain equipment, facilities, grounds, or personnel of the Institution, the undersigned participant does hereby waive liability, release an forever discharge Meals On Wheels Atlanta, its members individually, its officers, agents, or employees from any and all demands, rights and causes of action of whatever kind or nature, arising out of all known and unknown, foreseen and unforeseen bodily and personal injuries, damage to property and the consequence thereof, including death, resulting from my voluntary participation I or in any way connected with such programs and recreational activities.

I further covenant and agree that for the sole consideration stated above I will not sue Meals On Wheels Atlanta, its members individually, its officers, agents or employees for any claim for damages arising or growing out of my voluntary participation in programmatic or recreational activities.

I understand that the acceptance of this Release, Waiver of Liability and Covenant Not to Sue the Institution or any agent or employee thereof, shall not constitute a waiver, in whole or in part, of sovereign or official immunity by said Board, its members, officers, agents and employees. This Release, Waiver of Liability and Covenant Not to Sue shall remain in effect for as long as I am a participant in Adult Day Health programs or recreational activities by the Institution.

I certify that I am the primary caregiver of _____ and I am responsible for _____, personal and financial effects. I further attest that I am of age and suffering under no legal disabilities and that I have read the above carefully before signing.

Print Name:_____

Signature:_____

Date:_____

Witness Print Name:_____

Address:_____

Phone:_____