For Office Use Only:

Date Received: _____

Transportation:
_____

Jewish Home
ADULT DAY HEALTH CARE

Adult Day Health Care: Initial Screening Application

Please leave no blanks

Name: _____Preferred Name:_____

Address: _____

_____

Living Arrangements: _____(Living alone, with family, within an agency)

Phone Number: _____ Date of Birth: _____

Social Security Number: _____ Primary Language: _____

Medicaid Number: _____ Marital Status: ☐Single ☐ Married ☐ Widowed

MLTC/MMC Provider: _____ Gender at Birth:_____

Pronouns: _____ Gender Identity:_____

Contact Person/Care Manager: _____Phone #:_____

Email address: _____

Emergency Contact:

Name: _____ Phone #: _____

Relationship to Applicant: _____

Address: _____

Email address: _____

Power of Attorney: ☐**Yes** ☐**No**

Primary Care Physician:

Facility: _____Physician Name:_____

Address: _____

Phone Number: _____ Fax Number: _____

Seen in the last 12 months? ☐**Yes** ☐**No**

Does applicant have:

DNR/MOLST: ☐**Yes** ☐**No**

Legal Guardian: ☐**Yes** ☐**No**

Health Care Proxy: ☐**Yes** ☐**No**

Please attach these documents if applicable.

Program Interest: Day Program 8am-2pm ☐ or Evening Program 1pm-6pm ☐

Attendance Days: Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Services Needed: Physical Therapy ☐ Occupational Therapy ☐ Speech ☐

Transportation needed: ☐**Yes** ☐**No**

Preferred Hospital: _____

Support Needs: (Complete all information)

Diet: _____

Allergies to Food: ☐**Yes** ☐**No** If Yes: _____

Allergies to Medication: ☐**Yes** ☐**No** If Yes: _____

Any swallowing difficulties? ☐**Yes** ☐**No** Explain: _____

Check all that apply: Put details of care needs in the comment section below.

Mobility: ☐ Walker ☐ Wheelchair ☐ Cane ☐ No Device (Ambulatory)

Eating assistance: ☐ None ☐ Food Cut ☐ Observed ☐ Hand Fed ☐ Altered Consistency:

_____

Bladder: ☐ Continent ☐ Incontinent **Pads/Briefs:** ☐**Yes** ☐**No** If Yes, Size: _____

Bowel: ☐ Continent ☐ Incontinent

Toileting assist: ☐ None ☐ Some Assist ☐ Total Assist

Transferring Assistance Needed: Is a lift used, 1 person, 2 person assistance? Explain:

_____

Hearing: ☐ Within normal limits ☐ wears hearing aids ☐ Deaf ☐ Difficulty

Vision: ☐ Within functional limits ☐ wears corrective lenses ☐ partially impaired vision ☐ legally blind

Communication: (Check all that apply) ☐ Verbal ☐ Non-Verbal ☐ Difficult to understand

☐ Communication device ☐ Makes needs known ☐ can read/write

Medical Diagnoses/Concerns:

_____

_____

Psychosocial Concerns:

_____

_____

Adaptive Equipment Needed (AFO's, walker, brace, utensils, plates):

_____

_____

Community Agencies/Services Involved (Name, Agency, Phone Number, Service provided) Please be specific:

_____

_____

Will person require medications to be administered while at program? ☐Yes ☐No

If person will require medications to be given by a nurse while at program, be advised that all medications must come into program in a current labeled bottle. The label must have the person's name, medication name, dosage, frequency and route. If the person is self-medicating they must be able to identify the medication, why they are taking it and when they should be taking the medication. All medications must be transported securely and safely.

Comments:_____

_____

_____

If accepted into program, it is required that an initial assessment and care plan is completed. This will occur every 6 months. Is this person able to report medical, social and psychological information independently?

☐Yes ☐No

If they are not able to report independently, who will assist in these assessment times upon admission and every 6 months while enrolled in program services?

_____

_____

Referral Sources: _____ Phone: _____

How did you hear about us?_____

Thank you for your interest! You can return your referral by fax to 585-341-2413 or by mailing to:

Jewish Home
Attn: Adult Day Health Care
2021 Winton Road South
Rochester, NY 14618

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

Jewish Home of Rochester Adult Day Health Center. 2021 S.Winton Road. Rochester, NY 14618

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until Discharged (INSERT EXPIRATION DATE OR EVENT)

☑ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW _____ DATE _____

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE _____ SIGNATURE _____ DATE _____

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.