Farmingdale Adult Day Care Center
An Interfaith Ministry
1 Morton Street
Farmingdale, NY 11735
(516) 293-8928

For Office Use Only

Referral Source_____

Date of Intake_____

Days & Hours Preferred_____
Status:
Waiting_____

Active/Start Date_____

Name:_____
Last First Middle Nickname

Address: Phone:

_____ (____)_____
Street

_____ _____ _____ _____
City State Zip Code Township

Sex: M ¡ F ¡ Marital Status: ¡ Married ¡ Separated
¡ Never Married ¡ Divorced
¡ Widowed ¡ Unknown

Date of Birth:___/___/___
M D Y

Limited English Speaking:
Needs Interpreter ¡ Yes ¡ No ¡ Sometimes
Languages Spoken_____

Handicapped/Disabled: ¡ Yes ¡ No Specify (type):_____

Dr. Diagnosis_____

Income/Financial Support

Long Term Care Coverage_____

Veteran: ˚ Yes ˚ No

Religious Affiliation: ˚ Roman Catholic ˚Protestant_____
˚ Jewish ˚Other_____

What do you do during the day at home?_____

How often do you go out?_____ Where do you go?_____

How do you get to the places you need to go? _____

Transportation:
˚ Has own transportation
˚ Uses public transportation
˚ Needs Transportation
˚ Homebound

Household Composition:
# of People:_____
Relationship: (e.g. children)
_____

Housing: (e.g. own, rent)
_____

Personal History: (Born where, where did you grew up, nationality, work done for a living, special interests, etc)_____-
_____
_____
_____

NOTES: (**For Office Use Only)**
_____
_____
_____
_____
_____
_____
_____
_____

Registrants Bill of Rights

As a registrant of Farmingdale Adult Day Care, you have the right to:

1. Be treated with dignity, courtesy, privacy, and respect; regardless of race, religion, national origin, age, gender, sexual orientation, mental condition or handicap.
2. Have your property treated with respect. All registrants are advised not to bring large sums of money or valuables when they attend the program.
3. Have an environment that reflects an atmosphere of cleanliness, safety and comfort.
4. Be informed of all the rules and regulations of the agency.
5. Know the name and title of agency personnel who are providing service and supervision and to expect that they be properly qualified to provide care.
6. Be informed of the nature, purpose and frequency of care or procedures. Be informed of the potential benefits and burdens, as well as who will perform the procedure.
7. To refuse all or part of the care from the program, including social, religious and community groups. To be told the consequences of the decision to refuse.
8. Make informed decisions regarding your care. Receive information to help you make decisions and to participate in and planning your care. Expect to receive appropriate and quality care.
9. Be able to voice grievances to the Director, and to recommend changes in policies and services to program staff and/or outside representatives. To be protected from reprisals, interference, coercion, or discrimination as a result of what was said.
10. Expect reasonable continuity of care, timely delivery of services, coordination of treatment with your own primary care physician, and to have your preferences considered in planning and delivery of care.

Participant's Name_____

Family Member's Name_____

Family Member's Signature_____

Date_____

Complaints/Recommendations

Policy: It is the policy of Farmingdale Adult Day Care (FADC) to provide a means for all clients, caregivers, or designated representatives to present complaints or recommendations to the staff or Board of Directors, and for FADC to respond within 14 days after the complaint or recommendation was made.

Purpose: To ensure the exercise of client's rights without fear of reprisals, discrimination or discharge.
Coordination and follow through of all complaints/recommendations shall be the responsibility of the Program Director.

Any allegation of abuse, neglect or mistreatment shall be investigated.

Procedure: Upon admission, all clients and the designated representative shall be informed of the procedure to present complaints/recommendations and be given a Complaint/Recommendation Form. Complaints and/or recommendations can be made orally or in writing. Additional Complaint/Recommendation Forms are available through the Program Director.

All Complaint/Recommendations in writing shall be delivered to the Program Director. It is the responsibility of the Program Director to inform the Board of the Directors of the receipt of all Complaints and or Recommendations.

Participant's Name_____

Family Member's Name_____

Family Member's Signature_____

Date_____

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Emergency Contacts

Participants Name_____ D.O.B._____

A. Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Office Phone: _____
Cell Phone: _____

B. Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Office Phone: _____
Cell Phone: _____

C. Physician's Name _____ Phone ( ) _____
Address_____

HEALTH

Medications:
_____
_____
_____
Allergies_____
_____
Health Behaviors: _____
Diabetic (Y) (N)

NUTRITIONAL METABOLIC

Nutrition (Diet /Restrictions) _____
Appetite_____ Teeth: _____
Weight_____

EXERCISE & ACTIVITY

Mobility_____ Feeding _____
Toileting_____ Resp._____

**** Please notify the center of any change in physical or mental status, hospitalization or medication****

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Private Physician Evaluation Health Status Form

Physicians Name: _____Tel #_____

Patients Name: _____

Diagnosis:_____
_____
_____
_____

Surgery (Please list procedure and date)_____
_____
_____
_____

Last Physical Examination date:_____

Please check yes of any physical disorders are a current or continuing problem for your patient. If the condition is not present check no.

Atherosclerotic Heart Disease	YES_____	NO_____
Hypertension	YES_____	NO_____
Cerebral Arteriosclerosis	YES_____	NO_____
Other heart or circulatory disorders	YES_____	NO_____
Respiratory Disorder	YES_____	NO_____
Digestive Disorder	YES_____	NO_____
Obesity	YES_____	NO_____
Kidney Disorder	YES_____	NO_____
Urogenital Disorder	YES_____	NO_____
Fracture	YES_____	NO_____
Arthritis	YES_____	NO_____
Other Musculoskeletal Disorders	YES_____	NO_____
Diabetes	YES_____	NO_____
Other Metabolic Disorders	YES_____	NO_____
Eye Disease	YES_____	NO_____
Dermatological Disorder	YES_____	NO_____
Cancer	YES_____	NO_____
Paralysis	YES_____	NO_____
Parkinson's disease	YES_____	NO_____
Seizure Disorder	YES_____	NO_____
Other	YES_____	NO_____

Private Physical Evaluation Health Status Form

Diet: _____

Medication (Please print all medications and possible side effects):_____
_____
_____

Food Precautions/Allergies (Please print all medications and possible side effects):_____
_____
_____

To what extent will the patient's problem interfere with participation in the following?

Socialization: Needs evaluation___ not at all____ Mildly____ Moderately____ Severely____

Exercise: Needs evaluation___ Not at all____ Mildly____ Moderately____ Severely____

Arts & Crafts: Needs evaluation___ Not at all____ Mildly____ Moderately____ Severely____

Discussion Groups: Needs evaluation___ Not at all____ Mildly____ Moderately____ Severely____

How would you rate this patient's overall level of physical health? (check one)

Excellent____ Very Good____ Good____ Fair____ Poor____ Very Poor____

Please list recommendations, if any:_____
_____
_____

Please check those that apply:

Mental Status:
- Alert _____
- Impaired Judgment _____
- Agitated (nighttime) _____
- Hallucinates _____
- Severe Depression _____
- Assaultive _____
- Abusive _____
- Restraining Order _____
- Regressive Behavior _____
- Wanders _____
- Other (specify) _____

Impairments:
- Sight _____
- Hearing _____
- Speech _____
- Communication _____
- Other (specify) _____

May we contact you if necessary? Yes_____ No_____

Date: _____ Physician's Signature_____

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DNR
(Do Not Resuscitate)

It is very important that our staff at Farmingdale Adult Day Care knows if your loved one has a **DNR**. Here at Farmingdale Adult Day Care we need a copy on file and, please bring this form to your Dr. and have him or her fill this out.

Person's Name_____
Date of Birth __ / __ / __

Do not resuscitate the person named above.
Physician's Signature_____
Print Name _____
License Number _____ Date __ / __ / __

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Medical Release

Please read this:

In the event that an emergency situation occurs while your loved one is attending our program, expect that we will:

1. Assess any complaints or symptoms
2. Call the Farmingdale Fire Department
3. Contact you
4. Contact the Family Physician listed on our records, if necessary
5. Your family member will be taken to the St Joseph hospital if necessary accompanied by a staff member.

An immediate response will be made by all of us at our Center to ensure your family members well being at all times. We request your permission to release essential health data (diagnosis and medication) to the EMT's in the event an emergency occurs.

CONSENT:

I, _____, authorize Farmingdale Adult Day Care to release medical information pertaining to the health of my (Family Member Name) _____ , to the Nassau County Police Department (NCPD)/ Paramedics in the event an emergency occurs.

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Monday – Friday 9am-3pm

Financial Agreement

The fee for Adult Day Care is $42 per day. This includes complete supervision, activities, continental breakfast, hot meal (lunch), and snacks. All payments are in the form of check, made out to Farmingdale Adult Day Care. In memo line write FADC – "participant's name". Payment is due Friday morning or whatever day is the last day of the week he/she will be attending. **If we have to stay with anyone in the afternoon past 3PM we will be forced to charge the hourly wage of the employee who remains with the client.** We do ask to call in advance if your family member is not going to attend on a scheduled day.

* In the event of closing due to inclement weather, problems with the van or meeting place we will call you.*

FAMILY CONSENT: I hereby give agree to the terms above pertaining to the financial aspect of the Farmingdale Adult Day Care.

Family Member Name _____

Family Signature: _____

Date: _____

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Photo Consent

Periodically, we post photos taken during our program on our Farmingdale Adult Day Care Center Facebook page, our website, and/or the local newspaper. Please sign this document to authorize FADC posting photos of your loved with name (usually a group picture) participating in an activity.

Thank You,

Participant's Name_____

Family Member's Name_____

Family Member's Signature_____

Date_____

If you do **NOT** want any photos and name posted (with your family member in them)–please sign here_____