



Mindful Care Adult Day Services

(a program of Elders First ADS)

P.O. Box 332966; Murfreesboro TN 37133-2966
mindfulcareorg@gmail.com www.mindful-care.org
(615) 542-4371

Date: _____

Location: First United Methodist Church 265 Thompson Lane, Murfreesboro, TN 37133

Name: _____ Preferred Name to Be Called: _____

Address: _____

City / State / Zip Code: _____ Phone: _____

Applicant Personal Information - This information will remain confidential.

Social Security Number: _____ Medicare Number: _____ Birthdate: ____/____/____

Age: _____ Height: _____ Weight: _____ Sex: Male Female Race: _____

Applicant Preferences (Please Check)

Desired # of Days: _____ Full Day(s) or Half Day(s)

Preferred Days: Monday Tuesday Wednesday Thursday Friday Any Day First Available

Primary Caregiver or Responsible Person Information

(Emergency Contact) Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Place: _____ Work Phone: _____

Is the billing address the same? Yes No (If no, please provide correct information below.)

Billing Name: _____

Billing Address: _____ City / State / Zip Code: _____

How did you find out about Mindful Care Adult Day Services?

Primary Physicians - Hospital Preference

Doctor's Name: _____

Specialty: _____

Address: _____

City/State/Zip: _____

Phone: _____

Hospital Preference: _____

Applicant Assessment

If you answer yes, please explain.

Has there been any recent: Weight loss? Gain? No Amount: ___lbs. How Long: _____

Are there any drug allergies: Yes No

If "yes" list drugs: _____ Type of Reaction: _____

Are there any food allergies: Yes No

If "yes" list foods: _____ Type of Reaction: _____

Does participant consume tobacco products: Yes No How Much? _____

Applicant Assessment (cont.)

Can the Applicant Read? Yes No

Does the Applicant Write? Yes No

Is the Applicant: Left Handed Right Handed

Hearing Impairment:

Right Ear: No Loss Some Loss Complete Loss Hearing Aid Refuses to Wear Aid

Left Ear: No Loss Some Loss Complete Loss Hearing Aid Refuses to Wear Aid

Visual Impairment:

Left Eye: No Impairment Cataracts Implants Other: _____

Right Eye: No Impairment Cataracts Implants Other: _____

Glasses: Reading Distance Bifocals Does not wear glasses

Dentures: Yes No

Upper: Full Partial No Teeth Removable bridge

Lower: Full Partial No Teeth Removable bridge

Describe how well you think the applicant functions in the following areas.

Walking:

Steady on his/her feet Yes No
Without any help Yes No
With some help Yes No Explain: _____

Uses:
 Cane Crutches Walker Wheelchair Supervised walking

Eating:

Without Help Some Help _____ Needs to be prompted to eat
Please explain

Other considerations: _____

Swallowing:

Does the applicant have problems swallowing food? Yes No
Does the applicant store food mouth? Yes No

Diet:

Regular No Extra Sugar No Extra Salt Other Restrictions _____

Appetite:

Good Poor Eats too fast

Please list any food dislikes:

Toileting

Bladder:

Incontinence of Bladder: Yes No Nighttime Only

Products Used in Daytime: Nothing Panty Liners Pads Adult Diapers Other:

Help Required: None Reminders Prompting/Reminders Supervision (to and from restroom)

If there are any other toileting concerns, please explain:

Applicant Assessment (cont.)

Applicant Interests (Current and past.)

Previous Occupation: _____ Work Place: _____

Age at retirement: _____ Did the applicant adjust to retirement? _____

	Current	Past		Current	Past		Current	Past
Listening to Music	<input type="checkbox"/>	<input type="checkbox"/>	Singing	<input type="checkbox"/>	<input type="checkbox"/>	Playing Instrument	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	Games	<input type="checkbox"/>	<input type="checkbox"/>	Exercising	<input type="checkbox"/>	<input type="checkbox"/>
Knitting/Sewing	<input type="checkbox"/>	<input type="checkbox"/>	Drawing	<input type="checkbox"/>	<input type="checkbox"/>	Cooking/Baking	<input type="checkbox"/>	<input type="checkbox"/>
Gardening	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	Looking at Magazines	<input type="checkbox"/>	<input type="checkbox"/>
Handyman/Mr. Fixit	<input type="checkbox"/>	<input type="checkbox"/>	Dancing	<input type="checkbox"/>	<input type="checkbox"/>	Traveling	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	Grandchildren	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

How does the applicant currently spend his/her day?

Name of person completing this form: (Please Print) _____

General Applicant Data – OPTIONAL – For Statistical Purposes Only

Gender: Male Female Place of Birth: _____ Ethnic Background: _____
City/State

Year emigrated to US: _____ Primary Language Spoken: English Other: _____

Religion: _____

Is the applicant a veteran? Yes No

Education: 8th Grade High School College Other: _____

Marital Status: Single Married Divorced Separated Widowed

If widowed, how did he/she adjust?

What have we not asked you that you think we need to know?



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Name: _____

(Participant)

Attached is a medication sheet for the participants file, **every 3 months this medication sheet will be sent out to keep the participants file up to date.** If there are medications added that the participant will need to take while in the care of Mindful Care please make us aware of these changes so that we may keep the files as up to date as possible.

Per DHS licensing rules, there has been a change to our medication policy. **Participants must be able to self-medicate.** Staff may hand the bottle/container to the participants but the participant must be able to collect the medicine from the bottle/container themselves. Reason: because none of the staff are licensed to administer medicine we are only able to supervise the participants.

“Appropriate assistance or supervision by staff includes reading labels, opening bottles, reminding participants to take medication, checking the self-administered dose against the dosage shown on the prescription, observing the participant while taking medication, reassuring participants that he/she is taking the correct dosage, and reporting any noticeable changes in the condition of a participant to a physician and/or to the responsible party.

Under no circumstances shall an employee or volunteer provide any oral or topical medication, whether prescription or non-prescription, to a participant”

It may be best if only the amount of medication needed for the day is sent with the participant.

If you have any concerns or questions that you feel may be important for me to know, please feel free to call me.
Program: (615) 542-4371

Thank you so much for your continued support!

Managing Director, Cindi Thomas Mindful Care Adult Services (ADS) to allow _____,
(Participant)

to self-administer medicines while in the care of Mindful Care staff. I understand that

_____ and I assume responsibility for the proper use and safekeeping of this
(Participant)
medicine.

I acknowledge that Mindful Care ADS and their agents and employees are not liable for any injury arising from a participant's possession and self-administration of this medication while at Mindful Care ADS.

I further consent for the information included on this form to be shared with Mindful Care staff as necessary for the safety of the participant.

Authorized by:

Caregiver/Responsible Party

Date



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Special Instructions for any Medications:

Has the doctor diagnosed participant with any of the following?

- Allergies (specify _____)
- Anemia
- Arthritis or rheumatism
- Asthma
- Back or spine problems
- Cancer (site _____)
- Congestive heart failure
- Constipation
- Dementia (including Alzheimer's type)
- Diabetes (oral, injection or diet maintenance?)
- Emphysema, bronchitis, lung disease
- Epilepsy
- Heart disease (angina, pectoris heart attack, palpitations)
- Hypertension
- Inflammatory bowel disease (ulcerative colitis, Crohn's Disease)
- Kidney disease or stones
- Liver disease
- Parkinson's Disease
- Prostate trouble or trouble passing urine
- Stroke/TIA's (ministrokes)
- Ulcers or other stomach trouble
- Cataracts
- Glaucoma

Other (please list _____)



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Consent for Medical and/or Emergency Treatment

I, _____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures by Mindful Care staff as may in their professional judgement be necessary to provide for medical, or emergency care of my

(Relationship)

(Hereafter "dependent") - Full Name

I further give my consent to **Mindful Care Adult Day Service Staff**, who will be caring for my dependent on

(Days attending program)

from the times of _____.

In the event that my dependent is injured or ill while under the care of the caregiver, I hereby give permission to the caregiver to provide first aid for said dependent such as giving emergency medications such as Ibuprofen. I also give permission to the caregiver to take the appropriate measures in care of medical emergency such as contacting the Emergency Medical Service (EMS) system and arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my dependent, I direct that the caregiver first attempt to contact me. However, if medical care becomes essential, I give permission to the caregiver to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the caregiver on my behalf for the benefit of my dependent, I authorize the caregiver to request, obtain, review and inspect any and all information bearing upon my dependent's health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependent during this period.

Name of dependent _____

Allergies _____

Health Insurance Carrier _____

Health Insurance Policy # and Group # _____

Personal Care Physician _____

Address _____

Phone _____

Parent/Guardian Signature _____

Date _____

Daytime Phone Number _____

AUTHORIZATION FOR EMERGENCY CARE

I understand that Mindful Care Adult Day Services is a social agency and that no medical services are available. I hereby authorize Mindful Care Adult Day Services to have the above-named participant transported by ambulance for medical treatment in the event of an emergency. I agree to pay for all costs incurred. I also give permission for Mindful Care Adult Day Services staff to provide emergency medical personnel with any information which will assist them in the treatment of the emergency.

Signature Required:

Caregiver/Responsible Party

Date:

NOTICE AND AGREEMENT

The caregiver shall hold Mindful Care Adult Day Services harmless against all losses, damages, accidents or injuries to person or property of any participant or family member, guest, invitee or servant of the participant or caregiver caused by or resulting from or in connection their use or occupancy of the ADS premises or things in or about the ADS premises including travel to or from ADS.

Signature Required:

Caregiver/Responsible Party

Date:

WALKING FIELD TRIP AUTHORIZATION FORM

I give _____ permission to participate in walking field trips.

Signature Required:

Caregiver/Responsible Party

Date:



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Name of participant: _____ Date: _____

Statistical Information:

Mindful Care is the recipient of a Community Development Block Grant from the City of Murfreesboro.

This grant requires us to provide the income level of our participants and/or families **every year as the numbers change yearly.**

1. **Please circle the number of members in the home**
2. **Please circle the estimated income amount directly below the number of members in the home**

This information will only be used in the form of a statistical report with no names attached.

By circling a number it indicates the household income is **less than or equal to** that number based on number of persons in the household. **Average median income (AMI) for Nashville/Davidson - Murfreesboro-Franklin, TN is 80,000.**

30% of AMI is represented in the first line of income figures,
 50% of AMI (very low income) is represented by the second line of income amounts,
 80% of AMI (low income) is represented by the third line of income amounts.

Please Circle Number as it applies to your household:

Number In Home	1	2	3	4	5	6	7
-----------------------	---	---	---	---	---	---	---

Please Circle Income Amount as it applies to your household: (Please provide supporting documentation)

(If you choose to not provide supporting documentation, please still circle income amount and sign the below statement stating your amount exceeds)

Extremely Low (30% AMI) Income	16,800	19,200	21,600	25,750	30,170	34,590	39,010
Very Low (50% AMI) Income	28,000	32,000	36,000	40,000	43,200	46,400	49,600
Low (80% AMI) Income	44,800	51,200	57,600	64,000	69,150	74,250	79,400

 Signature of Primary Care Giver Date

If your family income **exceeds the amounts provided above,** please document by signing here: **(Please provide supporting documentation)**

 Signature of Primary Care Giver Date

If you choose **not to provide documentation supporting** the stated income you circled above or the amount your income exceeds, please sign here:

 Signature of Primary Care Giver Date

If you choose to **opt out of providing any income information as it applies to your household,** please document by signing here:

 Signature of Primary Care Giver Date

 Signature of Program Director Date



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Applicant _____ Caregiver _____

Financial Responsibility

I, (please print) _____ understand that I am responsible for all fees and
Caregiver/Responsible Party

charges incurred by (please print) _____ at Mindful Care ADS.
Participant

 Signature Required: _____ Date: _____

 Billing Address (if different than caregiver's address): _____ City/State/Zip _____

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LATE FEES

Care partners are required to pick up participants by the stated closing time.

Elders First Center Weekdays, Monday – Friday, 8:00 a.m - 5:00 p.m.
 A minimum of \$10.00 will be charged if a participant is picked up after closing time.

Fifteen (15) minutes after closing, an additional \$1.00 per minute will be charged FOR EACH MINUTE. This is non-negotiable. The clock in the ADS room is the clock used for arrival and departure times.

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Signature of Acknowledgement _____ Date _____
 Participant or Responsible Party _____

PHOTO /MEDIA/ARTWORK/RELEASE

I give to Mindful Care Adult Day Services unlimited permission to use, publish and republish in the furtherance of its work, reproductions of my likeness by photographic or electronic media means (such as television, Internet) for non-commercial and fundraising purposes, with the use of my first name. I give my permission for my voice to be recorded and my art work, or a reproduction to be used without compensation to me or to my family.

Please note: Failure to agree to Photo/Media/Artwork release will not affect your eligibility for the program.

 Caregiver Signature _____ Date _____



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Authorization for transportation pick up from Mindful Care Adult Day Services

Participant Name

Date

I hereby inform Mindful Care Adult Day Services that the people listed below are authorized to pick up the above named participant at any time.

Accordingly, Mindful Care Adult Day Services is hereby instructed to release _____ into the care of the following people whenever they come to Mindful Care.

Authorized pick up person

Name:

Relationship

Phone Number:

1. _____

2. _____

3. _____

4. _____

I understand that:

· Caregivers must inform Mindful Care Adult Day Service (call, leave a note at drop off) of the name of the person who is picking up participant on any day when they themselves are not.

· This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Authorized by:

Caregiver/Responsible Party

Date



Mindful Care Adult Day Service Participants' Bill Of Rights

At Mindful Care we are dedicated to providing you with quality health care services so you may remain as independent as possible. Our staff is committed to treating each and every participant with dignity and respect, and ensuring that all participants are involved in planning for their care and treatment.

As a Mindful Care participant, you have the following rights:

You Have The Right To Be Treated With Respect

- The right to be treated as an adult, with consideration, respect and dignity, including privacy in treatment and in care for personal needs;
- The right to be free from harm, including isolation, excessive medication, abuse, neglect and/or financial exploitation;
- The right to communicate with others and be understood by them to the extent of the participant's capability.

You Have The Right To Protection Against Discrimination

- The right to voice grievances about care or treatment without discrimination or reprisal;

You Have The Right To Information And Assistance

- The right to be fully informed, at the time of acceptance into the program, of services and activities available and related charges;
- The right to identifying information such as name, address, age, etc.
- The right to a copy of any power of attorney, any health care proxy, any advanced care directive, and any physician's orders for scope of treatment. (POST)
- The right to a copy of any existing and currently effective conservatorship and/or guardianship documents.

You Have The Right To A Choice of Providers

- The right to all primary caregivers and/or responsible party;

You Have The Right To Access Emergency Services

- The right to emergency contact information for primary caregiver or a responsible party and medical provider documented.

You Have The Right To Participate In Treatment Decisions

- The right to participate in developing or changing of care plan and services;
- The right to a thorough initial assessment, development of an individualized plan of care, and a determination of the required level of care;
- The right to be involved to the extent possible in program planning and operation;

You Have The Right To Have Your Health Information Kept Private

- The right to refuse treatment and be informed of the consequences of such refusal;
- The right to confidentiality and the guarantee that no personal or medial information will be released to persons not authorized under law to receive it without yourself or legal representatives written consent;

You Have The Right To File A Complaint

You Have The Right To decide whether or not to participate in any given activity

You Have The Right To Leave The Program at any time

Signature of Acknowledgement

Participant or Responsible Party _____ Date _____



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Physician's Statement Form

Date: _____

Patient (Name): _____

(Address): _____

Kindly complete the following information so that patient can be enrolled at the Mindful Care Adult Day Services program. This form can be returned to patient, patient's representative or mailed to Mindful Care

Primary Diagnosis: _____

Secondary Diagnosis: _____

I certify that _____ is free from any communicable diseases and is also able to participate in an adult day program with the following limitations:

Physical limitations: _____

Dietary limitations: _____

Allergies: _____

Date: _____

Physician Signature: _____

Physician Printed Name: _____