

A NEW LEAF, INC.

# Adult Day Care Enrollment Agreement



ISP Start Date: \_\_\_\_\_ 6-month: \_\_\_\_\_ End Date: \_\_\_\_\_

Name of person completing agreement: \_\_\_\_\_

## Contact Information:

Participant Last Name: _____	First: _____	M: _____
Participant birth date: ____/____/____	Nickname: _____	M: ____ F: ____ Age: _____
Address: _____	City: _____	Zip: _____
Home Ph#: _____	Cell#: _____	Alt#: _____
Emergency Contact#: _____	Name/Relation to Participant: _____	
SSN: ____-____-____	Medicaid#: _____	Healthy Connections#: _____
Whom does the participant reside with? _____		
Marital Status (please circle):	Single	Married
Parent/Legal Guardian: _____	Parent: _____	
Address (if diff. from participant) _____		
Name of Parent: _____	Ph# _____	Cell# _____
Name of Parent: _____	Ph# _____	Cell# _____

## Medical Information:

Primary Physician: _____	Ph# _____	Fax# _____
Address: _____	City: _____	Zip: _____
Specialist: _____	Ph# _____	Fax# _____
Address: _____	City: _____	Zip: _____
Specialist: _____	Ph# _____	Fax# _____
Address: _____	City: _____	Zip: _____
Dietary Considerations: _____		
Known Drug/Food Allergies: _____	Seizures: _____	Frequency _____
Primary Diagnosis: _____	Secondary Diagnosis: _____	
Required assistive devices: _____		
Other Pertinent Information: _____		
Dentist: _____	Ph# _____	Orthodontist (please circle): Y/N
Optometrist: _____	Ph# _____	

PA: S5100-U8 \_\_\_\_\_

## Current/Previous Agency Information:

Dev. Therapy Agency: \_\_\_\_\_  
 Agency Ph# \_\_\_\_\_ Fax# \_\_\_\_\_  
 Res Hab Agency: \_\_\_\_\_  
 Program Coordinator: \_\_\_\_\_  
 Agency Ph# \_\_\_\_\_ Fax# \_\_\_\_\_  
 Targeted Service Coordinator: \_\_\_\_\_ Agency: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Ph# \_\_\_\_\_ Fax# \_\_\_\_\_

## Medications:

	PRESCRIPTIONS	DOSE	SIDE EFFECTS
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
	PRN'S		
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

## Additional Information:

Favorite Likes: \_\_\_\_\_  
 Dislikes: \_\_\_\_\_  
 Is Participant sensory sensitive? If yes, please describe (clothing tags, fire alarms, food textures, touch, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## SERVICES PROVIDED:

ANL Adult Day Care shall provide services including, but not limited to, recreational activities, maintenance of self-help skills, assistance with activities of daily living, provisions for trips to social functions (transportation costs to social functions are not a Medicaid reimbursable service), and special diets.

ANL has a termination notice policy of a minimum of fifteen (15) calendar days written notice by either party unless waived by mutual written agreement.

Services may be terminated on notice shorter than fifteen (15) days under emergency or urgent circumstances, such as termination of ANL's provider agreement, a condition endangering the health, safety, or welfare of the participant, or if the participant presents a danger to self or others.

## ENROLLMENT CRITERIA:

ANL will enroll participants under the following conditions:

1. Accept only participants when they are able to provide the level or type of service the participant requires and an adequate number of skilled and/or licensed staff are available on site to deliver the service.
2. Participants who require skilled nursing may be enrolled when the care is within the licensed authority of ANL staff and a nurse is on site to perform the nursing service.
3. No participant shall be enrolled who has pressure ulcers or open wounds that are not healing.
4. No participant shall be enrolled who requires continuous nursing assessment and intervention.
5. No participant shall be enrolled who has draining wounds for which the drainage cannot be contained.
6. No participant shall be enrolled whose needs are beyond the level of fire safety provided by the facility.
7. No participant shall be enrolled whose physical, emotional, or social needs are not compatible with the other participants in the facility.

## MEDICATIONS:

Adult day care service providers must meet these minimum medication requirements:

1. Medications may only be administered by licensed nurses. Any staff who assists with medications must be licensed to do so or must successfully complete a Board of Nursing approved course on assistance with medication, as the delegatee of a licensed nurse.

2. Each hourly participant shall be responsible for bringing his/her own medications for the time spent in Adult Day Care.
3. ANL is responsible for safeguarding Adult Day Care participants' medications while they are at the facility/home.

## ACKNOWLEDGMENT OF ACCEPTANCE AND UNDERSTANDING:

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Signature of Parent/Guardian

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Date

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Signature of Participant if own Guardian

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Date