"The Best Days" Adult Health Center
Participant Application

ENROLLMENT APPLICATION

Date: _____ Referral Source: _____

APPLICANT INFORMATION

Name: _____

Nickname: _____SS#: _____

Address: _____

Date of Birth: _____Age: _____Gender: _____

Race: _____Marital Status: _____Military Record: _____

Employment History: _____

Applicant Lives With: _____# in household: _____

DAYS NEEDED	Tuesday		Thursday		
Full Day					
Half Day					

About our program…

The Best Days Adult Health Center (Best Days) is available two days per week for your loved one to receive clinical and social services in a safe and comfortable environment. We offer planned programs and activities that provide supervised care and companionship to older adults during the day in a professional care setting. Our programs are designed to promote well-being through health and social-related services. Safety is our highest priority. Please do not bring clients who have a fever, severe open wounds, or anything else that would put them or other clients at risk. We will expand to five days a week beginning in 2023.

4804 Highway 25
Montevallo, AL 35115
Phone: 205-490-8448

CAREGIVER INFORMATION

Primary Caregiver: _____

Relationship to Applicant: _____

Address (if different from applicant): _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employment: _____ Work Phone: _____

NAMES OF CHILDREN **ADDRESS** **PHONE #**

_____

_____

_____

NAMES OF SIBLINGS **PHONE #**

_____

_____

GENERAL INFORMATION

Does the applicant need assistance with: ***(please circle)***

Mobility **Toileting* *Feeding* *Special Diet* *Redirecting*

What kinds of activities does the applicant enjoy?

_____

_____

Please share any information that would be helpful when caring for the applicant: _____

_____

****If applicant requires incontinence supplies, the family will be required to provide them.***

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MEDICAL INFORMATION

Physician who diagnosed dementia: _____

Current medical problems: _____

_____

Other physicians currently seeing the applicant:

Name: _____Phone: _____

Does the applicant have any allergies? _____

(ex: food, medicines, skin, etc.)

Has applicant ever been diagnosed with tuberculosis? Yes _____No _____

If yes, list diagnosis date _____ Name of Physician _____

Has the applicant had a physical in the last year? Yes _____ No _____

List current prescription and over-the-counter medications and dosages

_____

_____

_____

_____

_____

_____

Will medication be administered during day care hours?

Yes _____No _____

Is there any medical problem that would put the applicant or other clients at risk in the day care setting? _____

_____

Does the applicant have a DNR (do not resuscitate) order? Yes ___No _____

Since Best Days is not a medical facility, we do not determine when a DNR should go into effect. For medical emergencies we will call 911 and request medical assistance.

Has someone been legally assigned as guardian for the applicant?

Yes _____ No _____

Name _____Phone _____

Address _____

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CLIENT PICK UP LIST

Name Phone #

_____

_____

_____

_____

_____

_____

EMERGENCY CONTACTS & INFORMATION

Primary Contact: _____Cell #:_____

Address: _____

Home #: _____Work #: _____

Secondary Contact: _____Phone #: _____

Hospital Preference: _____

The paramedics reserve the right to transport your loved one to a different hospital based on the type of medical emergency they identify with their medical assessment.

Insurance: _____ Policy#:_____

Caregivers are fully responsible for charges incurred in a medical emergency.

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RELEASE WAIVER

I hereby grant permission to Best Days to release/receive information and records including behavioral and medical reports on:

Name of Client/Patient: _____

Date of Birth: _____ Gender: _____

From *(list doctors):* Phone numbers:

_____ _____

_____ _____

Caregiver: _____

Address: _____

Signature: _____ Date: _____

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PUBLICITY RELEASE

To let the public, know about our program, there frequently are magazine, newspaper, and television stories about our day program. We also have displays at many events including senior days, churches, civic club meetings, and health fairs. Using pictures of clients and events at Best Days makes our program more real. The confidentiality of our clients is important to us, so we only use pictures if the family gives us permission. It does not affect whether a person is admitted to our program.

I, _____*(caregiver),* give permission for _____to be photographed or filmed for television, newspaper and other promotional uses for Best Days. Pictures and videos will be used to inform the public of our program, to educate volunteers and other interested persons, and to keep a record of events at the Center.

Signature: _____Date: _____

☐ ***Check box if you opt out...***

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CONDITIONS OF ADMISSION

Client Name: _____

Admission: Acceptance to Best Days will require a signed referral from a medical doctor and the application completed by a caregiver

1. Caregivers are responsible for getting clients into and out of the Center. If someone other than the Caregiver will be picking up the client, their name must be listed on the application or the workers at the Center need to be informed.
2. Caregivers are asked not to allow clients to bring anything of value to Best Days. Clients do not need money and jewelry is easily misplaced. Best Days will not be liable for loss or damage to any personal property. Best Days is not a medical facility, and we do not dispense a client's medication.
3. The cost to participate in the program is $40.00 daily. Statements will be sent to caregivers at the end of each month. Payment is due within 10 days of receipt of the bill. There will be a monthly late fee of $25 on overdue accounts and a $25 fee for returned checks. Checks should be made payable to Middle Alabama Area Agency on Aging (M4A). Caregivers who fail to settle their account within 10 days of the second notice will be advised in writing that the client is discharged from the program and the matter referred to our attorney for collection.

Caregiver signature _____Date _____

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ADMISSION, ATTENDANCE, LATE PICK-UP POLICY AND DISCHARGE

Admission: Individuals can be accepted into the program with evidence of:

- Physicians' referral and appropriate diagnosis
- Completion of Enrollment Application, Release Waiver, and Emergency Information form, and completion of a Financial Agreement

Exceptions to admission criteria may be made by the Director.

Attendance:

At the time of admission, an attendance schedule will be established for the client. Changes to that schedule will be approved by the Director.

Late Pick-Up Policy:

Please be on time to pick up our clients. Clients picked-up after 4:30 pm will result in a late fee* of $20.00 for any 10-minute increments beyond our hours of services. After 3 occurrences, we reserve the right to discontinue service.

Discharge:

The following would preclude participation in the program:

- **Requires continuous one-on-one supervision by Center staff**
- **Requires restraint for protection of self and others**
- **Medical needs exceed the capabilities of Center staff**
- **Inappropriate sexual or social behavior**
- **Diseases that are contagious by casual contact**
- **Failure to pay for care after the second notice**

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PHYSICIAN REFERRAL

Patient's Name: _____

Date of Birth: _____

Has patient been diagnosed with some form of dementia?

Yes ____No ____

If there has been a diagnosis, what date was the diagnosis completed? _____

Date of last complete physical examination: _____

Do you feel that this patient would benefit from a day care program?

_____

Are there any behavioral problems that we need to be aware of for your patient? If yes, please describe: _____

_____

_____

_____

_____

Physician's Signature_____

Print Physician's name_____Phone_____

Please fax completed form to

NEED FAX NUMBER

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