Reset Print

FOR OFFICE USE ONLY

Admission Date: _____

Discharge Date: _____

DB Admissions Packet – Part 2

1) MEMBER DATA FORM

Today's Date _____

Name_____Gender: Male____Female____

Address _____

City _____State_____Zip_____

Phone (_____)_____Marital Status: M W D S

Age_____ D.O.B._____/_____/_____ Social Security #_____-_____-_____

Is member a Veteran? Y or N If yes, what branch _____

Are any immediate family members a Veteran? If so, what is relationship to member? _____

Medicare #_____ Medicaid # _____ Other Health Insurance #_____

Veteran's Administration #_____ Long Term Care Insurance? Yes ____ No ____

Diagnosis_____

Physician_____

Phone (_____)_____Fax (_____)_____

Responsible Person / Caregiver _____

Address_____Home # (_____)_____

Work # (_____)_____ Cell # (_____)_____

Email address _____

Referral Source _____

EMERGENCY CONTACT

1) Name_____Relationship_____

Address_____

Home # _____Work # _____Cell # _____

2) Name_____Relationship_____

Address_____

Home # _____Work # _____Cell # _____

3) Name_____Relationship_____

Address_____

Home # _____Work # _____Cell # _____

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

2) SOCIAL HISTORY

Member's name:_____ Nickname:_____

Age:_____ Birthday is:_____ He/ She lives with:_____

Former occupation was:_____

Past hobbies were:_____

He/ She especially enjoys doing: _____

He/ She likes to eat:_____ His/ Her special diet is:_____

Diagnosis:_____Religious Preference is:_____

He/ She is a veteran/which branch:_____

Caregiver/ guardian name:_____Phone:_____

FAMILY SUPPORT SYSTEM IS:

SPOUSE NAME:_____

CHILDREN NAMES: _____GRANDCHILDREN: _____

GREAT GRANDCHILDREN: _____

My friend's names are: _____

Other important people – Names & Relation: _____

SOCIAL NEEDS/ CONCERNS:

_____

_____

List any areas of interest or favorites:

Books

Poetry

Movies

Music

Hand crafts

TV shows

Gardening

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

3) ACTIVITIES OF DAILY LIVING EVALUATION FORM

If member scores 17 or above Easterseals reserves the right to immediate discharge

BATHING

1. Independent – receives no assistance (get in and out of tub/shower by self)
2. Assisted – receives assistance in bathing only one part of body (such as back, legs, etc.)
3. Dependent – receives assistance in bathing more than one part of body (or does not bathe)

DRESSING

1. Independent – gets clothes and gets completely dressed without assistance
2. Assisted – gets clothes and gets dressed with minor help
3. Dependent – receives assistance in getting clothes and getting dressed or stays partly or completely undressed

TOILETING

1. Independent – goes to toilet, cleans self
2. Assisted – receives assistance in going to or in cleansing self or in arranging clothes after elimination or needs reminders
3. Dependent – doesn't go to room termed toilet for elimination, or wears protective pads

MOBILITY

1. Independent – able to ambulate without assistance from others or devices
2. Assisted – receives assistance with devices, such as cane or walker or needs on per accompaniment
3. Dependent – requires a wheelchair or more than one assist.

TRANSFER

1. Independent – moves in and out of a bed or chair without assistance (may be object supported such as with cane)
2. Assisted – moves in and out of a bed or chair with one person assisting
3. Dependent – does not get out of bed

CONTINENCE

1. Independent – controls urination and bowel movement completely by self
2. Dependent – has occasional "accidents"
3. Dependent – supervision helps urine or bowel control
4. Dependent – incontinent or catheter is used

FEEDING

1. Independent – feeds self without assistance
2. Assisted – feeds self except for assistance in cutting meat or arranging foods
3. Dependent – receives assistance in feeding

MEDICATIONS

1. Independent – able to take medications correctly and timely
2. Assisted – needs reminders and supervision of medications
3. Dependent – requires total administration of medications

SCORE = _____ **1-8 Independent** **9-16 Assisted** **17-25 Dependent**

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

4) MEDICAL HISTORY

Completed by:_____

Check all that apply:

☐ Heart disease or Angina	☐ Cerebrovascular accident /Stroke	☐ Kidney or Prostate disorder	☐ Thyroid Disorder	☐ Myocardial Infarction
☐ Diabetes mellitus	☐ Tuberculosis	☐ Asthma	☐ Hypertension	☐ Pulmonary disease
☐ Cancer	☐ Seizures attack	☐ Transient ischemic	☐ Pneumonia	☐ Fall or fracture
☐ Ulcers	☐ Rheumatoid Arthritis	☐ Osteoarthritis	☐ Parkinson's	☐ Dementia
☐ Alzheimer's	☐ Traumatic Brain Injury	☐ Bipolar	☐ Anemia	☐ Paranoia
☐ Schizophrenia	☐ Other			

☐ Allergies (Drug, Food, Other) Please Explain _____

PAST HISTORY USES:

_____ ☐ use/ used alcohol _____ ☐ use/ used tobacco _____ ☐ use/used drugs

COMMENTS:

_____

_____

_____

CURRENT TREATMENTS:

_____

_____

_____

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

5) HEALTH ASSESSMENT - FUNCTIONAL ABILITY

EQUIPMENT AND PERSONAL DEVICES

☐ Cane ☐ Shunt ☐ Prosthetic ☐ Dentures

☐ Walker ☐ Corrective Lenses ☐ Wheel Chair ☐ Hearing Aid

☐ Adaptive Devices ☐ Incontinent Equipment

Other_____

Activities of Daily Living:

I – Independently or A-Assistance Needed

Bathing _____
Dressing _____
Grooming _____
Eating _____
Ambulation _____
Toileting _____

Instrumental Activities of Daily Living

Shopping ____
Cooking ____
Meal Prep ____
Housekeeping ____
Laundry ____
Telephone ____
Finances ____
Medication ____

Toileting

_____reminders _____ supervision
_____ positioning _____ changing depends
_____ transfers _____ assistance with
_____ pads/depends

Communication – check ones that apply

_____ no apparent problems
_____ uses isolated words meaningfully
_____ answer yes/no questions appropriately
_____ has word finding difficulties
_____ speaks spontaneously but inappropriately
_____ uses communication device
_____ talks or babbles to self/mimics others

Orientation

_____ usually orientated
_____ usually disoriented
_____ Occasionally confused about:
___person ___place ___time

HAVE PROBLEMS WITH:

☐ VISION ☐ HEARING ☐ SPEECH ☐ SWALLOWING
☐ COMPREHENSION

COMPREHENSION/EMOTION/BEHAVIOR:

☐ becomes anxious/agitated ☐ demands constant attention ☐ hoards objects
☐ becomes verbally abusive ☐ wanders ☐ frequently appears depressed or withdrawn
☐ loses or misplaces things ☐ hallucinations ☐ sleep difficulties/naps frequently
☐ asks the same questions ☐ becomes combative ☐ engages in socially or inappropriate behavior
☐ denies or seems unaware that anything is wrong ☐ behavior is potentially dangerous to self or others

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

6) ASSESSMENT FOR FALLS

A. A check in one of these categories indicates automatic high risk rating:

_____ Patient who has a history of falls
_____ Patient who sustains a fall during current hospitalization
_____ Orthostatic Hypotension
_____ Motor deficits (decrease in mass, strength, coordination, loss of balance)

B. Patients who have potential to sustain falls due to:

1. Medical Conditions (history of any of the following:

_____ Transient Ischemic attacks (decreased circulation in brain causing vertigo, dizziness and fainting)
_____ Abnormal gait or posture due to pain, fatigue, arthritis, osteoporosis, Parkinson's disease
_____ Decreased vision and/or hearing acuity
_____ Inner ear or cerebral disease
_____ Urinary frequency and urgency; nocturia and/or incontinence (potential for unsafe maneuvering and toileting)
_____ Active heart disease, and/or arrhythmia
_____ Seizures
_____ Sensory deficits (decreased sensation in lower extremities)
_____ Foot problems

2. Medications:

_____ Diuretics and/or antihypertensives
_____ Sedatives, tranquilizers
_____ Antipsychotics, antidepressants

3. Mental Condition:

_____ Mental confusion
_____ Faulty judgments (impulsivity)
_____ Patient's perception of competence in own environment (high anxiety)

4. Environmental

_____ Walks with assistance/transfers with assistance
_____ Improper use of wheelchairs, walkers
_____ Ambulates with assistive devices
_____ Structural hazards

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

7) MEDICATION CONSENT FORM

The nurse at Easterseals Adult Day Health Care Center will be responsible for administering the following medications and/or treatments:

Medication name/Dosage	**Time medication is to be administered:**
_____	_____
_____	_____
_____	_____
_____	_____

It is the responsibility of the family/caregiver to **notify the nurse of any medication changes or any change in treatment or in diagnosis.** This will insure the continuity of care needed for your family member.

Please contact the nurse at the center with any of your concerns.

_____ _____

Member/Caregiver/or Guardian - print name Date

_____

Member/Caregiver/or Guardian - signature

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

8) MEDIA RELEASE

I hereby consent that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easterseals Florida or its respective employees and agents may be used by Easterseals Florida, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals Florida and that these materials may be released to the general public. I assign to Easterseals Florida all of my rights to these materials.

I understand that these materials made by Easterseals Florida, its employees and agents are owned by Easterseals Florida and that they may copyright them. I will allow Easterseals Florida, their respective employees and agents, and those acting with Easterseals Florida's permission, to use my protected health information, as defined under 45 C.F.R. 164.501, for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Florida and to release this information to the general public.

I understand that these materials may be published on Easterseals Florida's network of Web sites and this may disclose my personal and protected health information online.

Easterseals Florida does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easterseals Florida may decide not to use them.

I acknowledge that the rights described above are granted to Easterseals Florida on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals Florida will not condition any treatment or funding to me on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals Florida to release my protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Florida in writing by sending my revocation to Center Director. I understand and agree that once Easterseals Florida, its respective employees and agents, and those acting with its permission, disclose my protected health information as contemplated by this release, this information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This release and authorization expires three years from the date of my signature below.

I certify that I am over the age of 18 years old.

I have read this release and authorization before signing below, and I fully understand its contents.

_____

Signature of Adult or Caregiver/Parent/Guardian Witness for Easterseals Florida

_____

Printed Name of Adult or Parent/Guardian Date

_____

Date

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

9) PROGRAM AGREEMENT/CONTRACT

Easterseals Adult Day Health Care is operated as a community service by Easterseals Florida, Inc.

The member_____, SSN _____ and responsible person _____do hereby agree to the following terms and conditions for the admission to Easterseals Florida Adult Day Health Care Program..

The member/caregiver has been informed of the services currently offered by Easterseals Florida, Inc. Services shall include the day program, breakfast, lunch, and afternoon refreshments. Ancillary services are extra, see attached list of ancillary services offered. Services shall be provided to the member for _____days per week, with a minimum of two, but may, by mutual consent, include additional days on a temporary or permanent basis.

The basic fee is $65.00 per day.

The member/caregiver agrees to complete all the attached forms necessary for admission prior to the admitting date. The member/caregiver must provide a statement signed by a Florida licensed health care provider (Use the Physicians Referral Form in this admissions packet) documenting the member's freedom from tuberculosis in the communicable form and documenting the member's freedom from signs and symptoms of other communicable disease. This statement must have been signed prior to the member's admission by no more than 45 days.

The cost for basic services for this member shall be **$65.00 per day, or $308.75 per a five-day week** (a 5% discount for attending 5 consecutive days, M-F only). Not including transportation. This discount is not valid when receiving scholarship/financial assistance.

This agreement may be terminated by the written request of the responsible party at any time within 30 days after first being admitted without penalty. Thereafter, written notification to terminate services by either party shall be given fifteen (15) days prior to discharge, excluding a documented emergency situation, death of the Member or a prolonged illness/hospital stay. In the event the required notice is not given, the responsible party will be billed for an amount equal to 50% of the Member's normal service fees for the fifteen (15) day notification period.

Seasonal members are required to submit written notification fifteen (15) days prior to leaving the program. In the event the required notice is not given, the responsible party will be billed for an amount equal to 50% of the Member's normal service fees for the fifteen (15) day notification period. Upon return, seasonal Members will be placed on their day(s) of choice, subject to space and staffing availability.

The program closes at 5:30pm . If the member is not picked up by the designated closing time, a late pick-up charge of $1.00 per minute will be assessed. If the member remains in the program for one hour after closing without notification from caregiver of designated emergency contact on chart data sheet, a placement process will begin.

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

Easterseals Florida, Inc. will charge the per-day fee for any regularly scheduled day missed or canceled unless notice is received no later than 4:00 p.m. the previous day, except when the absence is due to an emergency situation (such as hospitalization or sudden illness).

When cancellation is for Monday, notification must be received by 4:00 p.m. the previous Friday. Cancellation for a day after a holiday must be received by 4:00 p.m. on the business day prior to the holiday.

All members may take a two-week vacation annually with the guarantee that their regularly scheduled days will be held without charge. After the second week, the participant's slot will be guaranteed under the following conditions:

(a) the participant pays 50% of the "basic" charges (the "holding fee")
(b) The holding fee must be paid in advance of the vacation.

("Basic fee" is defined as the regular daily or weekly fee, excluding transportation). If the holding fee is not paid, Easterseals Florida, Inc. cannot guarantee the Member's preferred days. Members will have the option to be placed on a waiting list if the program is at capacity, or being placed on different days.

Payment for the week is expected in advance of services on the first service day of the week. Non-payment is considered breach of contract. If payment is not received, member is at risk for discharge from the program (see attached "Fee and Schedule Agreement Document"). **Checks should be made payable to "Easterseals Florida, Inc.**" Credit card payments are also accepted.

All returned checks are subject to service charges and processing fees from Easterseals Florida, Inc.

No person will be admitted, nor any member retained in the program if he/she requires services beyond the scope of which Easterseals Florida, Inc. is capable of providing. Easterseals Florida, Inc. in its sole discretion may deny admission to any participant or previous member if such person is judged by to be a danger to himself/herself; or other members; or his/her behavior is unacceptable and interferes with the operation of the program.

By signing below, I agree to this Program Agreement / Contract.

_____ _____

Member/Caregiver/or Guardian Signature Date

_____ _____

Responsible party/legal guardian/next of kin Date

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

10) FEE AND SCHEDULE AGREEMENT – ADULT DAY HEALTH CARE

- I, _____ (**Caregiver name here**) agree with the admission documents that have been reviewed with me, and I wish to enroll my loved one, _____ (**Client/Member name here**) in the adult day health care program managed by Easterseals Florida, Inc.

- I agree to the following days per week (**Circle days to attend**): M T W TH FR

- I understand that the above days per week cannot be changed unless advanced notice is given by 4:00pm the day before. If days per week need to change permanently then a new schedule agreement must be completed and signed.

- I understand that there is a two (2) day per week minimum to attend.

- **For those that pay privately for service**, I understand that I will be charged the per-day fee for any regularly scheduled day(s) missed or canceled unless notice is received no later than 4:00 p.m. the previous day, except when the absence is due to an emergency situation (such as hospitalization or sudden illness).

- **For those who have the services paid by a third party (i.e., VA, Medicaid Managed Care, etc.),** I understand that Easterseals must have a valid service authorization and that I must attend on the days circled above. I also, understand that I must cancel service by 4:00pm the day before in order to not jeopardize funding and/ or services.

- **For those that pay privately for service** I agree to pay, **in-advance**, the correct fees for services – to be paid on the first day attending each week for that week or the first day attending for the month for that month. The fees are as follows:
  - Daily rate of adult day health care = $65.00 per day. (5% discount if attending 5 days in a week, Monday – Friday)
  - Bathing $25.00 – per bath/shower
  - Shave only $9.00
  - Other Services
    - Insulin check, $1.00 per check if member does not have supplies or if supplies provided by member do not meet the proper self- sheathing / self-retracting model.
    - Hair Care (if available at this location) – see rate sheet
    - Field Trips, when available - $15.00 per trip
    - Late pick-up fee is $1.00 per minute starting at 5:31pm.

  - **I understand that payments that are 10 or more days late will result in a 5% late charge per day thereafter.**
  - **I understand that payments that are 20 or more days late will result in suspension of our services.**

_____ _____

Signature of Client/Representative Date

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

11) AUTHORIZATIONS, CONSENTS & RELEASES

1. **Medical Information – Obtaining & Releasing -** Representatives and employees of Easterseals Florida, Inc., have my permission to communicate with the adult day health care participant's physician(s), authorized family member(s) listed on the client data form, service provider(s), case manager(s), or health care provider(s), about the participant's current physical, psychological, and emotional health, as well as any other types of potential problems or needs that the participant may experiencing or experience in the future as it pertains to attending the adult day health care program.

   _____ Initials

2. **Authorization for Emergency Medical Treatment -** In the event the Participant requires emergency medical treatment other than minor first aid, I authorize Easterseals staff to contact the participant's physician listed on the Physician Referral Form to render treatment. If the physician cannot be reached, staff should consult their Medical Director for treatment options or call Emergency Medical Services for treatment as necessary.

   _____ Initials

3. **Authorization for Emergency Medical Transportation -** Authorization is given for the above named Participant to be transported to the nearest hospital emergency room in the event of injury or acute illness.

   _____ Initials

4. **Guarantee of Payment**: For and in consideration of services rendered or to be rendered to this client by EASTERSEALS FLORIDA, I/WE, individually and jointly, here to agree to pay any and all bills rendered for said client which are not covered by insurance and/or third party payers, or otherwise paid. I understand and agree that all bills are payable and become due upon presentation.

   _____ Initials

5. **Assignment of Insurance Benefits**: I/We authorize and direct payment of the medical benefits arising from insurance or other coverage through which the patient is insured and covered, any and all other proceeds from any insurance and/or settlement or judgment, or out of a claim or lawsuit, directly to EASTERSEALS FLORIDA, but not to exceed the regular charges for services provided. I understand that I am responsible for all charges not paid through the above sources. I understand that I am responsible for any insurance deductible, co-pay and co-insurance.

   _____Initials, if applicable

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

6. **Photocopy Authorization & Signature on File** - A photocopy of this authorization consent and release form is acceptable with the same authority as the original. I authorize use of this form on all my insurance submissions, I authorize EASTERSEALS FLORIDA to act as my agent in helping me obtain payment directly to EASTERSEALS FLORIDA. I permit a copy of this authorization to be used in place of the original.

_____ Initials

Hold Harmless Agreement - The undersigned Participant/responsible relative/guardian (underline one) of ___ _____, hereby consents to said Participants use of the **facility, facilities equipment, and modes of transportation** provided by Easterseals Adult Day Services and releases its officials, agents, employees, and/or any and all claims, demands, damages, costs, expenses, loss of services, actions and cause of actions, which could arise out of any act or occurrence, and particularly on account of person injury, sustained by the said Participant, while said Participant is on the premises of Easterseals Adult Day Center, facility or vehicle or is on a trip, excursion, or outing sponsored by Easterseals Adult Day Services. I also certify that I fully understand the nature of all the above statements.

_____ _____

Member/Caregiver/Guardian- **Printed Name** Member/Caregiver/Guardian - **Signature**

_____ _____

Or Guardian/Attorney-in-Fact Date

Relationship to Member (client): _____

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

12) RECEIPTS

By initialing each item below and signing at the bottom of this Receipts Section confirms that I am in receipt of each mentioned document/procedure/guideline and have read and understand each.

1) _____Receipt of Comprehensive Emergency Management Plan

Initials

Easterseals Adult Day Health Care Programs follow the guidelines of the Agency for Health Care Administration in preparing a comprehensive emergency management plan.

This facility has an approved comprehensive emergency management plan.

Signing below indicates I have received a copy of the center's Comprehensive Emergency Management Plan, have one available to me or have read a copy. I understand that I can request a copy of the plan at any time.

****

2) _____ Receipt of Admissions Packet Part 1, 2 and 3, including Member/Caregiver Policies and Procedures

Initials

I have received, read and understand the Member/Caregiver Policies and Procedures provided in Part 1, Section 4, on Pages 4-6 of the Admissions Packet

****

3) _____ Member Rights and Responsibilities

Initials

I have received, read and understand the Members Rights and Responsibilities provided in Part 1, Section 5, on Pages 7 and 8 of the Admissions Packet

****

4) _____ Notice of Privacy Practices

Initials

I have received, read and understand the Notice of Privacy Practices provided in Part 1, Section 6, on Pages 9 - 11 of the Admissions Packet

****

5)_____ Receipt of all services provided, staffing positions and rates for all services.

Initials

I have received, read and understand the services provided, rates for all and staffing positions provided in Part 1, Sections 7, 8 and 9 on Pages 12 - 14 of the Admissions Packet

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

6)_____ Advanced Directive
Initials

I have received, read and understand the Healthcare Advanced Directive provided in Part 1, Section 11, on Page 16 - 17 of the Admissions Packet

****

7) _____ Receipt of Grievance/Complaint Procedure
Initials

I have received, read and understand the Grievance/Complaint Procedure information provided in Part 1, Section 12, on Page 18 of the Admissions Packet

****

8) _____ Receipt of Discharge Guidelines
Initials

I have received, read and understand the Discharge Guidelines provided in Part 1, Section 13, on Page 19 of the Admissions Packet

****

My signature below indicates I am in receipt of all 8 items above.

_____ _____

Member/Caregiver/or Guardian Signature Date

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

13) COMMUNICATION RELEASE FORM

Easterseals Florida will no longer send service invoices, program information and/or other correspondence through the U.S. mail.

Please provide your email address below for program information and other correspondence.

_____
Program / Facility Name

_____ _____
Guardian / Caregiver - Print Name Date

_____
Email Address

_____
Signature

Please list any other family members or friends you would like to invite in receiving information from Easterseals.

Print the person's name below and print their email address:

_____ _____

_____ _____

For office use only

Date to Development: _____ Staff Initials: _____

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

14) CAREGIVER SURVEY

We all know that being in a caregiver relationship is both rewarding and challenging and, in our role as being a provider of support services, Easterseals would like to find out how our services are impacting you and your loved one.

In an effort to better understand how you and your loved one are doing, Easterseals will be conducting two surveys. First, we will be surveying caregivers with the goal of learning how we might improve our services so as to provide better support. Second, we will be surveying your loved one in an effort to better understand how they perceive their physical and emotional health as well as their quality of life.

The survey results will also be used for development and marketing purposes, and for helping us apply for additional grant money.

The caregiver survey consists of some general questions about yourself, and additional questions about your well-being and quality of life. Please take a few moments to complete the survey. Your responses will be held completely confidential.

The survey is on the next page.

Thank you for your participation!

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

Caregiver Name:_____ Relationship to member:_____

Caregiver Age: ☐ Under 35 ☐ 36-40 ☐ 41-45 ☐ 46-50 ☐ 51-55 ☐ 56-60 ☐ 61-65 ☐ 66-70 ☐ 71-75 ☐ 76+

How will you spend your day while your loved one is at their Adult Day Services Program? (Select all that may apply)

☐ Employment ☐ School ☐ Volunteer Opportunities ☐ Errands ☐ Respite ☐ Other _____

How many days per week will your loved one attend their Adult Day Services Program? _____

PLEASE RESPOND TO THE FOLLOWING STATEMENTS USING THE GIVEN SCALES:

Never	Rarely	Sometimes	Often	Almost Always
1	2	3	4	5

1. My physical health suffers due to my caregiving responsibilities
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

2. As a caregiver, I do not have enough time for myself
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

3. My employment is negatively impacted due to my caregiving responsibilities (if not applicable, select 0)
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

4. My ability to attend to personal errands (shopping, appointments, exercise, school, etc.) is interfered with due to my caregiving responsibilities
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

5. I feel depressed due to my caregiving responsibilities
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

6. As a caregiver, I feel stressed and/or overwhelmed
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

7. My sleep is disturbed due to my caregiving responsibilities
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

8. I am certain that an Adult Day Services Program for my loved one will be helpful
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

9. My family prefers to keep our loved one at home as opposed to an assisted living facility
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

10. Overall, I am certain the programming at my Adult Day Services Program will have a positive effect on **my loved one's life**
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

11. Overall, I am certain the programming at my Adult Day Services Program will have a positive effect on **my life**
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Member Name: _____

Date: _____

Day Break Admissions Packet – Part 2

Add Most Current Adult Care Food Program two-sided income eligibility form here