



Mailing Address
3185 Hickory Hill Road
Memphis, TN 38115-2533
www.alzheimersdayservices.org
(901) 372-4585
(901) 370-5642

Two Locations:	
Kennedy Park Center 4585 Raleigh LaGrange (In Kennedy Park) Memphis, TN 38128-6413	Dorothy's Place 3185 Hickory Hill Road (Hickory Hill and Knight Arnold Road) Memphis, TN 38115-2533

Keeping Families Together – since 1983!

Applicant General Information

Name: _____ Preferred Name to Be Called: _____
 Address: _____
 City / State / Zip Code: _____ Phone: _____

Applicant Personal Information - This information will remain confidential.

Social Security Number: XXX-XX- _____ Medicare Number: XXX-XX- _____ Birth Date: ____ / ____ / ____
 Age: _____ Height: _____ Weight: _____ Sex: Male Female

Applicant Preferences (Please Check)

Preferred Center: Grashot/Raleigh LaGrange Dorothy's Place/Hickory Hill **Desired # of Days:** _____
Preferred Days: Monday Tuesday Wednesday Thursday Friday Any Day First Available

Primary Caregiver or Responsible Person Information

Name: _____ Relationship to Applicant: _____
 Address: _____
 City / State / Zip Code: _____ Home Phone: _____
 Work Place: _____ Work Hours: _____
 Work Phone: _____ Pager Number: _____
 Mobile Phone: _____ Other Phone: _____
 E-mail: _____

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 Alzheimer's Day Services? _____

Applicant _____

Caregiver _____

Advance Directives

Power of Attorney Living Will Do Not Resuscitate P.O.S.T None Other _____

Power Of Attorney's Name: _____

For office use only:

Please provide Alzheimer's Dementia Services with a copy of any that may apply.

Emergency Contacts and Persons Authorized to Transport Applicant (other than primary caregiver listed on page 1)

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

E-mail address: _____

For office use only:

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

E-mail address: _____

For office use only:

Name: _____ Relationship to Applicant: _____

Address: _____ City / State / Zip Code: _____

Home Phone: _____ Work Place: _____

Work Hours: _____ Work Phone: _____

Other Number: _____ Mobile Phone: _____

E-mail address: _____

For office use only:

Applicant _____ **Caregiver** _____

Emergency Contacts and Persons Authorized to Transport Applicant (other than primary caregiver on page 1)

Name: _____ Relationship to Applicant: _____
Address: _____ City / State / Zip Code: _____
Home Phone: _____ Work Place: _____
Work Hours: _____ Work Phone: _____
Other Number: _____ Mobile Phone: _____
E-mail address: _____ *For office use only:*

Name: _____ Relationship to Applicant: _____
Address: _____ City / State / Zip Code: _____
Home Phone: _____ Work Place: _____
Work Hours: _____ Work Phone: _____
Other Number: _____ Mobile Phone: _____
E-mail address: _____ *For office use only:*

Primary Physicians - Hospital Preference

Doctor's Name: _____ Doctor's Name: _____
Specialty: _____ Specialty: _____
Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____
Phone: _____ Phone: _____
Hospital Preference: _____ **Last Time Hospitalized:** _____
Reason for Hospitalization: _____ **Length of Stay:** _____
Long-term effects: _____

Safe Return Information

Is the Applicant registered in this national program for possible wanderers? Yes No
If you answer yes, please record registration number here: _____.

Applicant _____

Caregiver _____

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 What Drugs: _____ Type of Reaction: _____
Are there any Food Allergies: Yes No What Foods: _____ Type of Reaction: _____
Does He/She Smoke/Chew/Dip: Yes No How Much?: _____
Can the Applicant Read? Yes No
Does the Applicant Write? Yes No
Is the Applicant: Left Handed? Right Handed?

Hearing Impairment:

Right Ear: No Hearing Loss Some Hearing Loss Complete Hearing Loss Hearing Aid Refuses to Wear Aid
Left Ear: No Hearing Loss Some Hearing Loss Complete Hearing 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, explain: _____

Dentures: Yes No

Upper: Full Partial No Teeth Removable bridge No Teeth
Lower: Full Partial No Teeth Removable bridge No Teeth

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: _____
 Cane Crutches Walker Wheelchair Supervised walking One to one assistance

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

Other considerations: _____

Swallowing:
Does the applicant have problems swallowing his/her food? Yes No
Does the applicant store food in his/her mouth? Yes No

Diet:
 Regular No Extra Sugar No Extra Salt Other Restrictions _____

Appetite:
 Good Poor Eats too fast

Please list food dislikes or any eating concerns:

Applicant _____

Caregiver _____

Applicant Assessment (cont.)

Toileting

Bowel and Bladder:

Incontinence of Bladder: Yes No Nighttime Only

Incontinence of Bowel: Yes No Nighttime Only

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

Help Required: None Reminders Physical Assistance Positioning Supervision Hygiene Diapers

Any other toileting concerns? If so, please explain:

Dressing

Help Required:

None Lay out clothing Supervise only Verbal cuing Physical Assistance
 Cooperative Resistant

Behavior (Please check ALL that apply)

Communication

- Difficulty communicating wants and needs
- Difficulty completing sentences
- Sentences do not make sense
- Difficulty naming people
- Difficulty expressing self Please explain: _____
- Has difficulty concentrating on a task or activity
- Takes little or no interest in activities and will not start them by self
- Often asks the same questions over and over again
- Loses or misplaces objects
- Has difficulty following simple directions
- Hoards objects
- Wanders away from home: # of times: _____ Wanderer's Bracelet Medic Alert Bracelet
- Cannot be left alone, must be supervised
- Demands constant attention and will not let you out of sight
- Becomes verbally abusive When: _____
- Becomes combative When: _____
- Becomes anxious When: _____
- Becomes agitated When: _____
- Becomes stubborn or uncooperative When: _____
- Engages in embarrassing or socially inappropriate behavior How: _____
- Talks to people he/she doesn't know
- Denies or seems unaware that anything is wrong
- Reports seeing or hearing things that are not there
- Frequently appears depressed or withdrawn
- Engages in behavior that is potentially dangerous to self or others What: _____

Please list any other behavior that you may be aware of.

Personality

Before onset of Illness _____ Current _____

Pattern of relating to others Outgoing Involved Social Loner

Applicant _____

Caregiver _____

Applicant Assessment (cont)

Primary Caregiver Spouse Child Other _____

Who would you say is the primary person responsible for Applicant? _____

Does primary caregiver live with Applicant? Yes No

If no, living arrangements: Lives Alone Spouse Relative Hired Caregiver Other

Is primary caregiver employed? Full time Part time Does not work Will work in future

Does the primary caregiver attend a support group? Yes No

Does or has any other family member had AD? Yes No

Family Goals for daycare Socialization Stimulation Family Relief Supervision Other: _____

Names that the Applicant most remembers: Name: _____ Relationship to Participant _____

Name: _____ Relationship to Participant _____

Applicant Interests (Current and past.)

Previous Occupation: _____ Work Place: _____

	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/Painting	<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"/>
Pets	<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: _____

Year emigrated to US: _____ City/State _____ Primary Language Spoken: English Other: _____

Nickname: _____ Likes To Be Called: _____ Religion: _____

Age at retirement: _____ How did the applicant adjust to retirement? _____

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.



**These items will be discussed
during the pre-enrollment visit,
and may be signed at that time.
Signatures # 1, 2 and 3 are
required for enrollment**

FINANCIAL RESPONSIBILITY (REQUIRED)

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

fees and charges incurred by (please print) _____ at Alzheimer's &
"Friend"
 Dementia Services of Memphis, Inc. above and beyond fees not covered by _____ such
Insert Third Party Payer
 as late fees, Drop-In extra days or bathing fees.

Sign Here: # 1 Signature **Date**

Caregiver/Relative/Responsible Party

Billing Address if different than caregiver's address:

 City/State/Zip

AUTHORIZATION FOR EMERGENCY CARE (REQUIRED)

I understand that Alzheimer's & Dementia Services is a social agency and that no medical services are available at Alzheimer's & Dementia Services. I hereby authorize Alzheimer's & Dementia Services of Memphis, Inc. to have the above named "Friend" 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 ADS' staff to provide emergency medical personnel with any information which will assist them in the treatment of the emergency.

Sign Here: # 2 Signature **Date**

Caregiver/Relative/Responsible Party

NOTICE AND AGREEMENT (REQUIRED)

The caregiver shall hold Alzheimer's & Dementia Services of Memphis, Inc. (ADS) harmless against all losses, damages, accidents or injuries to person or property of any "Friend" or family member, guest, invitee or servant of the "Friend" or caregiver caused by or resulting from or in connection with his/her/their use or occupancy of the ADS premises or things in or about the ADS premises including travel to or from ADS.

Sign Here: # 3 Signature **Date**

Caregiver/Relative/Responsible Party



Alzheimer's &
Dementia Services
of Memphis, Inc.

CURRENT MEDICATIONS

Please list **ALL** medications being taken **if changes are made**. List both **PRESCRIPTION** and **NON-PRESCRIPTION**, Over-the-counter drugs, herbal, and natural supplements, **whether they are taken at the center or not**. In an emergency, EMT's will ask about **ALL** medications being taken. Be very clear about how the medication is taken (1 twice a day or 2 once a day – 1 bid, 2 qd, also the dosage – mg or mcg or units, etc.)

CAREGIVER'S SIGNATURE: _____ DATE: _____

PARTICIPANT NAME: _____

DATE	MEDICATION NAME	DOSE	FREQUENCY	REASON FOR TAKING	WILL TAKE AT CENTER
(Example) 10/10/2000	(Example) Risperdal	(Example) 0.5 mg	(Example) 1 tab each day	(Example) Anxiety	(Example) Yes / (No) Yes/No
					Yes/No
					Yes/No
					Yes/No
					Yes/No
					Yes/No
					Yes/No
					Yes/No
					Yes/No

* All medications will remain the same unless changes, additions and deletions have been noted above.

Physician's Statement Form

Fax return to: (901) 370-5642



DATE: _____

TO: _____

MD Fax: _____

Your Patient (Name): _____

(Address): _____

is making application to attend the Alzheimer's Adult Day Services program. Please complete the following and return to Alzheimer's Dementia Services of Memphis , 3185 Hickory Hill Road, Memphis, TN 38115-2533 or FAX to (901) 370-5642.

Your patient cannot be enrolled until this form is returned to us:

Primary Diagnosis: _____

Secondary Diagnosis: _____
(use back if necessary)

Date of last examination: _____

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: _____

Physician's Name: _____

Address: _____

Phone: _____

Date: _____ Signature: _____

MEDICAL RECORD RELEASE

To: _____
(Doctor, Hospital, or Health Department)

Address: _____
Address City/State Zip Code

I hereby authorize and request you to release to:

**Alzheimer's and Dementia Services of Memphis, Inc.
(901) 372-4585**

**Location at:
4585 Raleigh LaGrange
Memphis, TN 38128-6413**

**Mailing Address
3185 Hickory Hill Road
Memphis, TN 38115-2533**

**Location at:
3185 Hickory Hill
Memphis, TN 38115-2533**

Name: _____
(Patient)

Address: _____
Address City/State Zip Code

Medical Records and/or other information concerning my illness and/or treatment of _____

Sign Here: _____ Date: _____
(Participant or Responsible Party)



Photo/Media/Artwork Release and Authorization

Please Print

Friend's Name: _____ **Date:** _____

Caregiver's Name: _____

Agency Name: Alzheimer's & Dementia Services **Date:** _____

I consent to and authorize my photograph being taken and my voice being recorded, along with any other audio/visual recordings or images of my by Alzheimer's & Dementia Services of Memphis, Inc. (ADS). My authorization applies to reproductions and use of my likeness, voice, art work and first name by photographic or electronic media means, such as still or moving photographs or digital images, television, and Internet, for any non-commercial use, and specifically, publicity and fundraising by ADS. I give my permission for my image and voice to be recorded and for my art work, or a reproduction, to be used in the manner described above without compensation to me or to my family.

I authorize and give ADS unlimited permission to use, publish and republish my image and voice and art work in the manner described above for all past, present and future periods. My authorization shall continue and remain in effect until I withdraw my authorization. I have received a copy of this Authorization.

Additional Health Information Disclosed. I understand and agree that the above described use of any photographs/recordings authorized by me may also disclose Protected Health Information, and I authorize such disclosure.

Signing of Authorization is the "Friend's" Choice: I understand that I am not required to sign this Authorization and my decision not to sign will not affect any care, payment, enrollment or eligibility for any benefits.

Withdrawal of authorization: If I sign this Authorization, I may revoke or withdraw the Authorization at any time by giving written notice to Executive Director of ADS at 3185 Hickory Hill Road, Memphis, TN 38115. A withdrawal of this Authorization will not prevent ADS' continued use of any of the above described records, information, photographs, audio/visual recordings or other information already used/released in reliance upon the Authorization. A photocopy or faxed copy of this signed Authorization shall constitute a valid authorization. During recording or filming, I have the right to stop the recording/filming of me at any time.

Release of Liability: I agree that ADS, including its governing Board, agents and employees, are released and held harmless from legal responsibility or liability for their access to and release of my information, images, recordings and art work.

Re-Disclosure: I understand that once the above described information, images, recordings and art work art work are disclosed, it may no longer be protected by federal or state law.

Sign Here:

Signature of Friend **Date**

AND/OR

Caregiver/Relative/Responsible Party **Date**

Decline Authorization at This Time

Caregiver/Relative/Responsible Party **Date**