Global Mobile Care
Adult Day Services

CLIENT APPLICATION

Client Information

Name: _____ Preferred Name to be called: _____

Address: _____

City / State / Zip Code: _____ Phone: _____

Medicare Number: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Primary Language: _____ Other Languages Spoken: _____

Education: ☐ 8th grade ☐ High School ☐ College ☐ Other: _____

Previous Occupation(s): _____ Work place: _____

Age at retirement: _____ Adjustment to retirement: ☐ Good ☐ Difficult

Veteran: ☐ No ☐ Yes Service: _____ Eligible for VA benefits? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Responsible Party Information/Primary Caregiver

Name: _____ Relationship to Client: _____

Address: _____

City / State / Zip Code: _____ Home Phone: _____

Work Place: _____ Work Phone: _____

Email address: _____ Cell Phone: _____

Does the primary caregiver live with the applicant? ☐ Yes ☐ No

If no, living arrangements: ☐ Lives alone ☐ Spouse ☐ Relative ☐ Hired caregiver

☐ Other: _____

Is the primary family caregiver employed?

☐ Full time ☐ Part time ☐ Does not work outside the home ☐ Will work in the future

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CLIENT ASSESSMENT FORM

Name: _____ Date: _____

Diagnosis of memory impairment:

Memory impairment? ☐ Yes ☐ No

Has client been diagnosed with dementia? ☐ Yes ☐ No

Hearing Impairment:

Right Ear: ☐ No loss ☐ Some loss ☐ complete loss ☐ Hearing Aid ☐ Refuses to wear

Left Ear: ☐ No loss ☐ Some loss ☐ Complete loss ☐ Hearing Aid ☐ Refuses to wear

Visual Impairment:

Right Eye: ☐ No impairment ☐ Cataracts ☐ Implants ☐ Other: _____

Left Eye: ☐ No impairment ☐ Cataracts ☐ Implants ☐ Other: _____

Glasses: ☐ Yes ☐ No ☐ Does not wear, explain: _____

Dentures: ☐ Yes ☐ No

Upper: ☐ Full ☐ Partial ☐ No teeth ☐ removable bridge

Lower: ☐ Full ☐ Partial ☐ No teeth ☐ removable bridge

Walking:

Steady on his/her feet: ☐ Yes ☐ No

Needs some help: ☐ Yes ☐ No Please explain: _____

Assistive Equipment: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ One to one assistance

Eating:

☐ Without help ☐ Some help ☐ Needs prompting to eat.

☐ Other considerations and food favorites or dislikes: _____

Swallowing:

Does the applicant have problems swallowing his/her food? ☐ Yes ☐ No

Does the applicant store food in his/her mouth? ☐ Yes ☐ No

Does the applicant have problems with choking? ☐ Yes ☐ No

If yes, are there certain foods that cause choking? _____

Diet:

☐ Regular ☐ No extra sugar ☐ No extra salt ☐ Other restrictions: _____

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CLIENT ASSESSMENT FORM

Appetite:

☐ Good ☐ Poor ☐ Eats too fast ☐ Other information:_____

Favorite morning beverage? _____

Has there been any recent ☐ Weight loss ☐ Gain ☐ Neither amount: _____lbs.

Does he/she smoke? ☐ Yes ☐ No (Please note that we are a smoke-free facility)

Toileting:

Incontinent of bladder: ☐ Yes ☐ No ☐ Nighttime only

Incontinent of bowel: ☐ Yes ☐ No ☐ Nighttime only

Products used in daytime: ☐ Nothing ☐ Liners pads ☐ Disposable underwear

Help required: ☐ None ☐ Reminders ☐ Physical Assistance

Positioning Supervision ☐ Changing ☐ Disposable garments

If a wheelchair and physical assistance are used, is the applicant able to stand and support his/her weight long enough to safely transfer to the toilet (abt 2 min.)? ☐ Yes ☐ No

Dressing:

Help required: ☐ None ☐ Lay out clothing ☐ Verbal cuing ☐ Physical assistance

☐ Other: _____

Bathing/showering:

Help required: ☐ None ☐ Verbal cuing ☐ Physical assistance

Level of Conversation/Language:

☐ Yes ☐ No: Is able to converse in most social situations

☐ Yes ☐ No: Uses full sentences with descriptive details

☐ Yes ☐ No: Can communicate basic wants and needs

☐ Yes ☐ No: Understands directions for activities (to dress, eat, go outside, etc.)

☐ Yes ☐ No: Can recall most recent events and conversations

☐ Yes ☐ No: Can name family members they see regularly

Behavior:

please check all that apply

☐ Confusion about current events in their life

☐ Confusion about time and place

☐ Sentences do not make sense, may ramble

☐ Problems with judgment: making important decisions

☐ Can't handle major life decisions

CLIENT ASSESSMENT FORM

- ☐ Difficulty: please check all that apply
- ☐ 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 or tells the same stories over and over again
- ☐ Becomes anxious in noisy environments
- ☐ Hoards objects
- ☐ Wanders away from home: # of times: _____ Wears a Medic Alert bracelet? ☐ Yes ☐ No
- ☐ Cannot be left at home alone, must be supervised
- ☐ Requires constant attention and will not let you out of sight
- ☐ Becomes verbally abusive When: _____
- ☐ Becomes combative When: _____
- ☐ Becomes anxious When: _____
- ☐ Are there any words/subjects that upset him/her? Please explain:

- ☐ Engages in embarrassing or socially inappropriate behavior. What?_____
- ☐ Talks to people he/she does not know
- ☐ Denies or seems unaware that anything is wrong
- ☐ Reports seeing or hearing things that are not there
- ☐ Has episodes of paranoia Please explain: _____
- ☐ Appears depressed
- ☐ Afraid of dogs
- ☐ Engages in behavior that is potentially dangerous to self or others; Please explain:

Please list any other behaviors/habits or challenges that would be helpful for us to know.

_____

Personality:

- ☐ Current patterns of relating to others: Outgoing Social Quiet Solitary
- ☐ Does the applicant read? ☐ Yes ☐ No If Yes, what? _____
- ☐ Does the applicant write? ☐ Yes ☐ No
- ☐ Has the applicant ever used a computer? ☐ Yes ☐ No

Favorite things/Preferences and Life Experiences:

Place of Birth: _____

If applicable, Cultural background: _____

CLIENT ASSESSMENT FORM

If a veteran, where did the applicant serve and what did they do?

Brief work history:

Number of children: _____

Personal Interests:

Faith-based activities and/or community service work:

Faith-based habits/rituals/beliefs that would be important for us to know:

Hobbies/Interests:

Art Experiences/Talent:

Music Experiences: ☐ Did/does the applicant play an instrument? ☐ Sing in a group?

☐ Play in a band? ☐ Dance? ☐ Other? _____

What genre of music do they like to listen to? _____

Favorite reading materials, poems, stories, authors, magazines, etc.?

_____

How does the applicant currently spend their time during the day?

CLIENT ASSESSMENT FORM

Family Long Term Plan of Care:

Do you need information about?

- ☐ Long Term Care facilities
- ☐ Respite Care
- ☐ In Home Care
- ☐ Home Delivered Meals
- ☐ Insurance

Would you be interested in information or attending any of our groups? Please check.

- ☐ General Virtual Caregivers Support Groups
- ☐ Adult Children Caring for a Parent Caregiver Support Groups
- ☐ Monthly Caregiver Information Workshop

Name of person completing this form: _____

Signature: _____ Date: _____

Global Mobile Care
Adult Day Services

POLICY AGREEMENT

Global Mobile Care's mission to is "Compassion, Dignity, Respect". Our goal is to help your loved one to grow and to achieve a better quality of life. We are dedicated to providing services that support and contribute to the success and well-being of both our clients and their families. Our goal is to provide quality care to all clients and to provide quality, creative, and an enjoyable atmosphere that encourages social, emotional, physical and intellectual growth of the loved one as a whole. Should you have any questions, please let us know.

ARRIVAL AND DEPARTURE

The Center is open Monday through Friday from 6:00 a.m. to 6:00 p.m. Clients are required to sign in and out. Caregivers must list other authorized persons on the enrollment application, if they are to pick up the client. Your loved one will not be released to persons not listed. Only the people on your emergency and pick-up lists, or those for whom you give written permission, will be allowed to pick up your loved one.

CLOTHING

Clients should be dressed in washable, comfortable clothing. Please provide each client with a sweater or jacket if they should need it. All extra clothing should be marked with the client's name. We assume no responsibility for jewelry.

FOOD AND REST PERIODS

The Center will meet the client's nutritional needs in accordance with USDA guidelines by providing a light breakfast, a well-balanced lunch, and a nutritious afternoon snack. Substitutions will be allowed for clients with allergies or who require special diets, upon a physician's written advice. Clients are allowed to rest as needed.

MEDICATION AND ILLNESSES

The Center is not equipped or staffed to provide care for sick clients. For the protection of ALL clients, it is our policy to exclude any client who has a temperature higher than 100 (or has had one in the past 24 hours); diarrhea or vomiting; an undiagnosed rash; discharging eyes or ears, profuse nasal drainage - no matter what is causing these symptoms since this requires special attention from the staff. Clients must be picked up within the hour after being notified and must have been FREE of these symptoms for 24 hours when they return to the Center. The center does provide medication reminders.

TRANSPORTATION

We provide transportation to and from the center and for field trips with permission.

FEES

Global Mobile Care accepts checks or money orders. Receipts will only be issued upon request. There will be a $30.00 charge for all returned checks and may be required following a returned check. A two (2) week notice is required for withdrawals. If fees are not kept current, your loved one will not be allowed to attend until fees are brought up to date. Delinquent accounts will be forwarded to a collection agency. If you have any special circumstances, please talk to the Center Director.

HOLIDAYS AND VACATIONS

The Center will be closed the following days: Thanksgiving Day, Christmas Day, New Year's Day, and Independence Day. In the event of inclement weather, please listen to the radio or television during news reporting.

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MEDICAL EMERGENCIES

In the event of a medical emergency or an accident, we shall contact the caregiver and the doctor of the client. If it is impossible to reach either and emergency treatment is required, the client will be taken to the hospital chosen on the clients file. Your authorization for the Center to contact your family physician and to take whatever emergency medical procedures are deemed necessary as part of this agreement.

If the expenses are over $100, our policy in the event of an accident, the Director will complete an incident/accident report.

PHOTOGRAPHS AND PUBLICITY

Photographs of the clients participating in our programs may be taken from time to time and may appear in newspapers, magazines, brochures, or other publicity materials. Your permission for photographs including your client's participation without compensation is part of this agreement.

FINAL THOUGHTS

The Center admits all clients without regard to race, nationality, disability, or religious background.

Our policy does not encourage staff to provide personal care services to families. Should such an agreement occur between staff and families, Global Mobile Care shall not be responsible for any acts or omissions of a staff member when such services are rendered.

Our Center has an open door policy and welcomes families at any time. Parents are encouraged to participate in our parent education programs, the staff process, volunteer activities, program planning and field trips. You're welcomed and encouraged to stop by anytime!

I have read the Policy Agreement and I understand that:

1) Fees are due on at the begning of the week. Clients may be made by check or money order. If fees are not kept current, the client will not be able to attend until fees are brought up to date. A $10.00 fee will be added to late payments.

2) The Center cannot accept a client who has a temperature higher than 100 (or has had one in the past 24 hours); diarrhea or vomiting; an undiagnosed rash; discharging eyes or ears, profuse nasal drainage. Clients must be picked up within the hour after being notified and must have been free of these symptoms for 24 hours when they return to the Center.

3) The Center reserves the right to terminate client care services. The following circumstances will warrant termination of services for a client. However, this list is not all inclusive:
   - i) Non-payment of fees.
   - iii) Late pick-ups.
   - ii) Families or clients being rude or discourteous toward management, staff or clients.
   - iv) A client demonstrating behavior that is hazardous to the health and safety of other clients or requiring continued one-on-one attention from the staff.

4) Clients must be signed in and out. Clients will only be released to authorized individuals.

5) Medication must be in original prescription bottle with the client's name. Only medication reminders will be given.

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6) Please see that the client is suitably dressed for both inside and outside activities.

7) Families are to notify the center of any changes in work, home or emergency contact phone numbers.

- I certify that the client is normal and healthy and in case of an accident or illness, Global Mobile Care has my authority to secure medical attention in the event of an emergency. I also authorize any licensed physician or medical treatment facility to treat my client in the event of an emergency. I understand the fees does not include accident and illness insurance.

- I hereby authorize Global Mobile Care to transport the client to and/or from center and center-sponsored activities and to release the Center of all liability other than reasonable care. Trips may be taken by walking or riding in the Center's vehicles and/or public transportation.

- I give permission to Global Mobile Care to use photographs, film footage or tape recordings, which may include the client's image or voice for any purpose Global Mobile Care deems proper, and I relinquish all rights, title and interest in the finished photographs, negatives or tape footage.

- I authorize Global Mobile Care to include the client in physical activities. I, the undersigned, do hereby release Global Mobile Care its employees and agents from any and all claims for injury, death, loss or damage I or my loved one may suffer, resulting from or occurring during these activities.

- I have read the Policy Statement and agree with the conditions as stated. I have also received a copy of the State Licensing Requirements for Adult Day Care Centers.

For office use only:	Enrollment Fee: $30	Client Fee/Payer Source: $ _____

_____ _____
Caregiver's Signature *Date Signed*

_____ _____
Center Representative's Signature *Date Signed*

Global Mobile Care
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Participant Health Policy Agreement

Reporting: Symptoms of Illness

I agree to report to the center when I have:

1. Fever and/or cough
2. Shortness of Breath
3. Diarrhea
4. Vomiting
5. Dizziness
6. Jaundice (yellowing of the skin and/or eyes)
7. Sore throat with fever
8. Infected cuts or wounds, or lesions containing pus on the hand, wrist, an exposed body part (such as boils and infected wounds, however small).

Reporting: Diagnosed Illnesses

I agree to report to the manager when I have:

1. Coronavirus (COVID-19)
2. Norovirus
3. Salmonella Typhi (typhoid fever)
4. Shigella spp. infection
5. E. coli infection (Escherichia coli O157:H7 or other EHEC/STEC infection)
6. Hepatitis A

   Note: The center must report to the Health Department when a participant has one of these illnesses.

Reporting: Exposure of Illness

I agree to report to the center when I have been exposed to any of the illnesses listed above through:

1. An outbreak of Coronavirus, Norovirus, typhoid fever, Shigella spp. infection, E. coli infection, or Hepatitis A.
2. A household member with Coronavirus, Norovirus, typhoid fever, Shigella spp. infection, E. coli infection, or hepatitis A.
3. A household member attending or working in a setting with an outbreak of Coronavirus, Norovirus, typhoid fever, Shigella spp. infection, E. coli infection, or Hepatitis A.

Exclusion and Restriction from Attending

If you have any of the symptoms or illnesses listed above, you may be excluded or restricted from the center.

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Participant Health Policy Agreement

Returning to the Center

If you are excluded from work for exhibiting symptoms of a sore throat with fever or for having jaundice (yellowing of the skin and/ or eyes), Coronavirus, Norovirus, Salmonella Typhii (typhoid fever), Shigella spp. infection, E. coli infection, and/or Hepatitis A, you will not be able to return to work until Health Department approval is granted or proof of negative test.

Agreement

I understand that I must:

1. Report when I have or have been exposed to any of the symptoms or illnesses listed above; and
2. Comply with center restrictions and/or exclusions that are given to me.

Participant Name (please print): _____

Signature of Participant or Authorized agent: _____ Date: _____

Latest COVID 19 Test Date: _____ Results: _____

Latest Flu shot Date:_____ Declined to take: _____