Evergreen
Adult Day Services

3434 Kildaire Farm Road, #129
Cary, NC 27518
(919) 238-4738
www.EvergreenAdultDayServices.net

PARTICIPANT REGISTRATION INFORMATION

Participant name:		
Birthdate:		Age:
Social security number:		
Address:		
City:	State:	zip:
Home phone:	Mobile phone:	
Email:		
Primary language:		
Marital status:	Living with:	

Primary Caregiver's name:		Relationship:	
Address:	City:	State:	Zip:
Home phone:	Cell:	Work phone:	
Email address:			

Emergency Contact 1:	Relationship:
Home Phone:	Mobile Phone:
Email:	Work Phone:
Emergency Contact 2:	Relationship:
Home Phone:	Mobile Phone:
Email:	Work Phone:

Emergency Care Authorization

In the event of an emergency, I give permission for _____ to be transported to the nearest emergency room or to my preferred hospital (depending on the nature of the emergency). I understand that I am responsible for all the charges resulting from the emergency care, including ambulance or rescue squad charges. I also give permission for EADS staff to provide emergency medical personnel with any information that will assist them in treatment of the emergency.

Preferred Hospital: _____

Caregiver's signature: _____ date: _____

Participant name: _____ Date of Birth: _____

Healthcare Profile

Physician Information

Participant's physician:	Specialty:
Address:	Phone:

Diagnoses:
Allergies:
Dietary restrictions:

Advanced Directives Notification

☐ My family member does not require a Power if Attorney (POA), may make his/her own medical or other decisions, and my sign for himself/herself legally.

☐ My family member has a POA or legal guardian.
name / number: _____

☐ My family member has an advance directive and **I will provide Evergreen ADS with an original copy.**

☐ My family member does not have an advance directive and would like information.

☐ My family member does not want an advance directive.

☐ My family member has a **DNR**. **I will provide Evergreen Adult Day Services with an original copy.**

Persons authorized to drop off and pick up participant from Evergreen Adult Days Services:

Name:	Email:
Home Phone:	Mobile Phone:

Name:	Email:
Home Phone:	Mobile Phone:

Other Information:

Participant name: _____ Date of Birth: _____

Level of Care Chart

	Basic Level Care Minimal or no assist	**Enhanced Level Care** Moderate Assist 2 or more in this column	**Advanced Level Care** Major Assist 2 or more in this column
Mobilizing & Ambulating	_____ Needs no help or requires only verbal reminders. Uses assistive devices independently.	_____ Needs prompting to safely transfer, mobilize and ambulate. Does not use assistive devices independently. History of falls within past 90 days.	_____ Requires physical assist for safe transfers, mobilization ambulation. History of falls within past 90 days
Eating & Drinking	_____ Needs no help or requires only verbal reminders.	_____ Needs assist with food cutting & placement or frequent prompting.	_____ Needs spoon feeding by staff. Unable to feed oneself
Toileting	_____ Needs no help or requires only verbal reminders.	_____ Escort or Prompting required	_____ Needs help dressing, undressing, transfers, cleaning.
Cognition & Behavior	_____ Requiring redirection or intervention 1-2 times per day	_____ Requiring redirection or intervention 3-5 times per day	_____ Requiring redirection or intervention 6-8 times per day

Participant name: _____ Date of Birth: _____

Enrollment Agreement & Attendance Plan 2018

____ $ 100 Annual Enrollment & Assessment Fee applied each calendar year

Add-On Days as needed: Payments for as-needed days are due at the time of scheduling.
_____ $82.50 per day –Basic Level of care _____ $93 per day –Enhanced Level of care

Monthly plans for Pre-schedule & Prepaid (includes 10% discount)
_____(initial) Payment for monthly plans are **due the first day** of every month.
Please check the days of week participant will attend.

Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____

Monthly COST	Basic Level Care	Enhanced Level Care	Advanced Level Care
5-days / week	____ $ 1561	____ $ 1755	____ $ 2048
4-days /week	____ $ 1248	____ $ 1404	____ $ 1638
3-days / week	____ $ 937	____ $ 1053	____ $ 1228
2-days / week	____ $ 624	____ $ 702	____ $ 819
1-day / week	____ $ 312	____ $ 351	____ $ 410

Reschedule, Cancellation, Withdrawal Policy:

_____(initial) Only illness or injuries requiring a doctor's office visit or hospitalizations are considered involuntary schedule changes. All other changes to attendance will be considered voluntary. No refunds or credits will be given for voluntary rescheduling.

_____(initial) A 24-hour notice is required to reschedule attendance dates within the same month. Please note that space may not always be available on your desired dates. No refunds or credits will be given for voluntary rescheduling. Any reimbursements or refunds for involuntary schedule change will be determined on a case-by-case basis.

_____(initial) A 24-hour notice is required to cancel attendance dates. Normal fees will apply during this time. Any reimbursements or refunds for involuntary cancellations will be determined on a case-by-case basis.

_____(initial) A 30-day written notice is required to withdraw from the program. Normal fees will apply during this time. Any reimbursements or refunds for involuntary withdrawal from the program will be determined on a case-by-case basis.

_____ _____

Signature Responsible Party DATE:

Participant name: _____ Date of Birth: _____

Payment Agreement 2018

- Evergreen accepts check or credit card. Cash is accepted for transactions of $50 or less.
- Medicaid eligible participants enrolled in the CAP-DA program may enroll
- Detailed Monthly invoice with level of service, number of days attended per month and any ancillary services used will be provided upon request at the end of each month which may be used for Veterans Administration, Long Term Care Insurance or other re-imbursement programs.

_____ I will pay by check by the first weekday of the month for scheduled services.

_____ Charge my credit card on file for scheduled monthly services

Name as it appears on Card: _____ ZIP code: _____

Credit Card #: _____ exp. date: _____ CVV code: _____

Signature: _____ Date: _____

Receipt and Acknowledgement of Program Policies

I have received my copy of Evergreen Adult Day Services' Program Policies dated March 2017. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures contained within.

I understand the rates and schedule of payment policy as stated above. I understand failure to pay this charge is grounds for termination of services. By signing below, I acknowledge that I agree to pay for services as charged.

We, Caregiver/Participant, agree to comply with the rules and regulations stated in this agreement and the Caregiver/Participant Handbook.

_____ _____

Signature Responsible Party DATE:

_____ _____

Signature of Director/Staff DATE:

Participant name: _____ Date of Birth: _____

CONFIDENTIALITY

All information in the participants file will be used only for emergency needs and for staff to aid in the proper care of the participant.

Only information needed to assist in the care of the participant will be released.

All information will be kept confidential and shared with no other agency or organization without written consent from participant or guardian.

_____ _____

Signature Participant/Guardian Date

_____ _____

Signature of Director/Staff DATE:

RELEASE PROTECTED INFORMATION FORM

I authorize *Evergreen Adult Day Services* to disclose the participants protected health information to his/her healthcare providers or emergency services when deemed necessary to provide appropriate treatment and to maintain the participant's well-being.

_____ _____

Signature Participant/Guardian Date

_____ _____

Signature of Director/Staff DATE:

RECEIVE PROTECTED INFORMATION FORM

I authorize *Evergreen Adult Day Services* to receive any medical information from the participant's healthcare provider(MD/NP/PA) when deemed necessary to provide appropriate treatment and to maintain the participant's health and wellbeing.

_____ _____

Signature Participant/Guardian Date

_____ _____

Signature of Director/Staff DATE:

Participant name: _____ Date of Birth: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PARTICIPANT PHOTOGRAPHIC AND/OR VIDEO IMAGES

Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by *Evergreen Adult Day Services* Center. I understand that information disclosed pursuant to this authorization such as photographs, video and/or interview content may disclose the fact that I am or have been a member of *Evergreen Adult Day Services*.

Purpose:

The photographic/video images and/or testimonial may be used for publicity, educational, marketing, advertising and fundraising purposes through internal publications, external publication, radio, television, video or internet. (I have crossed out any purposes or media format I do not wish included.)

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 10 years from date signed.

I understand that *Evergreen Adult Day Services* Center cannot condition treatment on whether I sign this authorization.

_____ _____

Signature Participant/Guardian Date

_____ _____

Center Director/Staff Date