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 the 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: _______________

Receipt and Acknowledgement of Program Policies

I have received my copy of Evergreen Adult Day Services' Program Policies. 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 Participant/Guardian Date

Signature of Director/Staff DATE:

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 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 Center.
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 Center cannot condition treatment on whether I sign this authorization.

Signature Participant/Guardian 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: ________________

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. Has 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, and cleaning. Has incontinence.
Cognition & Behavior	____ Requires redirection or intervention 1-2 times per day.	____ Requires redirection or intervention 3-5 times per day.	____ Requires redirection or intervention 6-8 times per day.
Skilled Nursing / Medication	____ Requires no medication or only scheduled oral medication on site	____ Requires as needed oral medication or injectable medication while on site. Requires weekly or more frequent vital signs monitoring.	____ Requires sliding scale or carb counting injectable medication while on site. Requires medial appliance care such as tube feeding, catheter or ostomy care.

Payment Agreement & Credit Card on File 2019

- Evergreen accepts check or credit card. Cash is accepted for transactions of $50 or less.
- 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.

____ The participant is a Medicaid CAP-DA program or HCCB Grant recipient

____ 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: _______________

Participant name: ____ Date of Birth: _______________

Enrollment, Attendance and Payment Plan 2019

Monthly plans for Pre-schedule & Prepaid (includes 10% discount)

Please check the days of the week the participant will attend.

Monday _____ Tuesday _____ Wednesday ____ Thursday ____ Friday _____

COST	Basic Level Care	Enhanced Level Care	Advanced Level Care
5-days per week	____ $ 1606	____ $ 1814	____ $ 2041
4-days per week	____ $ 1285	____ $ 1452	____ $ 1633
3-days per week	____ $ 964	____ $ 1088	____ $ 1225
2-days per week	____ $ 643	____ $ 726	____ $ 816
1-day per week	____ $ 321	____ $ 363	____ $ 408

Add-On Days as needed: Payments for as-needed days are due at the time of scheduling.

____ $85 per day –Basic Level of care
____ $96 per day –Enhanced Level of care
____ $108 per day –Advanced Level of care

________(Initial) **$100 Annual Enrollment & Assessment Fee is applied each calendar year.**

________(Initial) **Payments by check or credit card on file are due by the first day of the month for scheduled services.**

________(Initial) **A late fee of $1 per minute will apply to any departures after 6:00 PM**.

________(Initial) **Full Showers** are available at **-** $22.00

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: