Volunteers of America®
Oregon

Office Use Only
Client/CG offered copy of intake packet:
Accepted: Declined:
Date:

Participant Contact Information

Center: Marie Smith Center **Address**: 4616 N Albina Ave, Portland OR 97217 **Phone**: (503) 335-9980 **Fax**: (503) 335-0993

Client Information

Name: **DOB:** **Age:** **Gender:** -Select- **Marital Status:** -Select-

Address: **City:** **State:** **Zip:**

Phone: **Email:** **Referral Source:** -Select-

Immigrant: ☐ Yes ☐ No **Veteran:** ☐ Yes ☐ No **Living Situation:** -Select-

Ethnicity: **Language(s):** **Religious Preference:**

Transportation

Caregiver: ☐ **Tri-Met Lift:** ☐ **Medical Transportation:** ☐ **Other:**

Visitors At The Center:

Is there anyone that should NOT visit the participant at the center? ☐ Yes ☐ No **If "Yes", please list and explain.**

Case Management Information

Case Manager: **Phone:**

Email: **Fax:**

Emergency Contact Information

Primary: **Phone:** **Cell:** **Email:**

Relation: **Address:** **City:** **State:** **Zip:**

Secondary: **Phone:** **Cell:** **Email:**

Relation: **Address:** **City:** **State:** **Zip:**

Physician Contact Information

Primary: **Phone:** **Fax:** **Email:**

Address: **City:** **State:** **Zip:**

Secondary: **Phone:** **Fax:** **Email:**

Address: **City:** **State:** **Zip:**

Participant's Health Insurance: **Participant's Hospital Preference:**

Billing Information

Billing Method(s): **Private Pay:** ☐ **Medicaid:** ☐ **VA:** ☐ **OPI:** ☐ Other: ☐

Responsible Billing Party: **Relationship:** **Phone:**

Address: **City:** **State:** **Zip:**

Prime or ID #: **VA#:** **Medicaid Branch #:**

Authorized # of Days:

Participant Health Information

Advanced Directives

Does the participant have a **POLST** (or other advanced planning document)? ☐ Yes ☐ No

Other Health Care Professionals

Physician: **Phone:** **Fax:** **Specialty:**

Address: **City:** **State:** **Zip:**

Physician: **Phone:** **Fax:** **Specialty:**

Address: **City:** **State:** **Zip:**

Physician: **Phone:** **Fax:** **Specialty:**

Address: **City:** **State:** **Zip:**

Diagnosis and Health Concerns

(Please mark with an "X" for diagnosis or "M" if medications are taken)

___ **Dementia**	___ **Diabetes**	___ **Dizziness**	___ **Cancer** _____
___ **Hypertension**	___ **Stroke**	___ **Thyroid Problem(s)**	___ **Mental Health** _____
___ **Arthritis**	___ **Heart Disease**	___ **Parkinson's**	___ **Allergies** (Please list any food, drug, animal, or other allergy below)
___ **Seizures**	___ **Osteoporosis**	___ **Alcohol/Drug Abuse**	_____
___ **COPD**	___ **Skin Problems**	___ **Respiratory Issues**	_____

___ **Other Concerns:**

Does Participant smoke? ☐ Yes ☐ No **Can they smoke safely and independently?** ☐ Yes ☐ No

Did they smoke in the past? ☐ Yes ☐ No **How Long?** **When did they quit?**

Will they smoke at the center? ☐ Yes ☐ No

Sensory & Communication

Vision: ☐ Good ☐ Fair ☐ Poor ☐ Blind **Glasses:** ☐ Yes ☐ No

Concerns:

Hearing: ☐ Good ☐ Fair ☐ Poor ☐ Deaf **Hearing Aide:** ☐ Yes ☐ No

Concerns:

How well can the participant comprehend others?

Can they communicate their needs?

Dining Needs *(*Please note: family must provide food for special diets such as vegan, kosher, gluten-free, etc)*

Eats Independelty: ☐ Yes ☐ No **If "No", needs:** ☐ Cues ☐ Prompts ☐ 1 on 1

Diet (Check all that apply) ☐ Regular ☐ Diabetic ☐ Vegetarian ☐ Vegan* ☐ Kosher* ☐ Gluten-Free*

☐ Soft ☐ Puree ☐ Pre-cut ☐ Small Portion ☐ Other (Write below)

Ensure or other supplements? ☐ Yes (*Must be supplied by family*) ☐ No

If Yes, please specify:

Fluid Restrictions: ☐ Yes ☐ No **If "Yes", please explain:**

Needs Thick Liquids? ☐ Yes ☐ No **At Risk for Dehydration?** ☐ Yes ☐ No

Special Instructions, if any:

Participant Health Information

Mobility *(Please check all that apply)*

☐ Independent ☐ Stand-by assist ☐ W/C ☐ Walker ☐ Cane ☐ Quad cane ☐ Fall risk

Does participant have an exercise program? ☐ Yes ☐ No

Transfer Assistance *(Please check all that apply)*

☐ Independent ☐ Stand-by assist ☐ Needs cueing ☐ 1 person assist ☐ 2 person assist

Comments:

Sleep

Does participant need to nap at the center? ☐ Yes ☐ No **If "Yes", how long?**

Sleep pattern: ☐ Good ☐ Fair ☐ Poor **Describe any problems/concerns:**

Wandering/Confusion

Does participant try to leave regularly? ☐ Yes ☐ No

Redirection techniques you find helpful:

Are there any of the following behaviors related to confusion that we should know about?

☐ Anxiety ☐ Physical Outbursts ☐ Verbal Outbursts ☐ Hallucinations ☐ Delusions

If so, please explain:

Restrooming

Toileting: ☐ Independent ☐ Needs to be shown bathroom ☐ Wears pads
☐ has/needs toileting schedule ☐ Needs assistance in bathroom ☐ Needs Reminder

Bladder: ☐ Uncontrolled bladder incontinence ☐ Catheter ☐ Frequent UTIs

Bowel: ☐ Frequent bowel incontinence ☐ Constipation ☐ Colostomy (must be self-maintaining)
☐ Frequent diarrhea Known causes of diarrhea?:

Please describe the assistance needed or any concerns regarding toileting:

Additional Services *(Please select any services that you'd like the participant to receive)*

☐ Wander Tag
☐ Nail care
☐ Foot care*
☐ Shower (w/assistance)*
☐ Assistive Dining
☐ Blood sugar testing (if diabetic)
☐ Insulin injection
☐ Blood pressure monitoring
☐ Weight monitoring
☐ UTI Screening/Testing
☐ Nurse consultation
☐ Medication administration
☐ Functional maintenance therapy
☐ Caregiver support group

Fee for service

I have reviewed the information on this form, and to the best of my knowledge, it is accurate.

X

Participant/Caregiver signature Date

Volunteers of America Permissions

Authorization for Emergency Medical Treatment

Please read the Emergency Medical Treatment Policy before signing.

If the participant is found to be pulseless and not breathing:

☐ Day center staff has permission to perform CPR until EMS personnell arrive or the participant begins to breath on his/her own.

☐ The participant has/will submit a POLST or DNR that shows he/she does not want to be resuscitated. Staff should honor these orders.

Note: This form alone cannot act as a POLST or DNR order. The day center must have current POLST or DNR orders on file upon enrollment in order to honor the participant's wish to deny resuscitation. If the day center does not have these documents on file, staff WILL start CPR if the participant is found to be pulseless and not breathing until EMS personnel arrive or the participant begins breathing on his/her own.

Urine Dip Screening Permission

If the day center staff suspects that the participant may have a urinary tract infection, the day center RN or designee:

☐ has permission to collect urine fromhim/her and do a urine dip screening for a UTI.

☐ does **not** have permission to collect urine fromhim/her and do a urine dip screening for a UTI.

Media Release Permission

Occasionally, Volunteers of America Oregon may use photos and/or video footage of participants for advertising purposes. This includes, but is not limited to: TV/radio, internet ads, brochures, newsletters, and social media (Facebook, Twitter, etc). This authorization may be revoked at any time.

☐ I allow Volunteers of America to take photographs and/or video footage for the reasons state above.

☐ I **do not** allow Volunteers of America to take photographs and/or video footage for the reasons state above.

Outings Permission

Approximately once a month the day center will go on an outing. It can either be a scenic drive or a trip to a local attraction that may require getting off the bus. Every outing will be adequately staffed with day center staff and volunteers as needed to meet the needs of the clients attending. Participation in these trips is strictly voluntary. The day center also reserves the right to decline taking a client for reason including, but not limited to: medical needs, potential wandering, behavioral issues, excessive incontinence issues, limited space, etc.

_____

Participant name

☐ may participate in outings offered by the day center.

☐ may **not** participate in outings offered by the day center.

Policies and Procedures Review

Attached to this intake packet are the following VOA policies: "**Services, Eligibility, Payment, and Billing Agreement**", "**Participant Rights**", "**Emergency Medical Treatment Policy and Procedures**", and the "**Notice of Privacy Practices**". Please take a moment to review the policies and then sign below.

The day center has provided me copies of the policies listed above. I have read and understand the policies and procedures set forth by VOA and the day center.

_____ _____

Participant Name *Family/Care Giver Name*

_____ _____

Participant/Care Giver Signature *Date*

Volunteers of America Oregon
Adult Day Services
Authorization for Release of Information

Participant name: _____ DOB: _____

I hereby authorize _____
Name of physician, LPN, therapist, medical professional, etc

_____
Address City State Zip

_____ _____
Telephone Number Fax Number

To Disclose To and Receive From: Volunteers of America Oregon Adult Day Services Programs.

- ☐ Marie Smith Adult Day Center: 4616 N. Albina Street, Portland, OR 97217 fax: 503-335-0993
- ☐ Lambert House Adult Day Center: 2600 SE 170th, Portland, OR 97236 fax: 503-760-2192

The following information from my records (mark all sections below "yes" or "no"):

Yes	No		Yes	No	
☐	☐	Admission	☐	☐	Lab work
☐	☐	Insurance/billing	☐	☐	Discharge information
☐	☐	Nursing assessment	☐	☐	Care plan information
☐	☐	Medication list	☐	☐	Case management notes
☐	☐	Diagnosis	☐	☐	Other: _____

The purpose of the exchange or disclosure of information is to (mark all sections below):

Yes	No		Yes	No	
☐	☐	Plan treatment/services	☐	☐	Facilitate on-going treatment/services
☐	☐	Summarized treatment	☐	☐	Coordinate discharge

Other (specify)_____

Volunteers of America Oregon cannot condition treatment, enrollment or eligibility if the above named person refuses to sign this form.
I understand that this consent is subject to my revocation at any time except to the extent that action as already been taken as a result of my signed agreement. Unless I revoke my consent, this agreement will remain in effect for 90 days from the date of my discharge. Once we disclose the information it may no longer be protected by Federal HIPAA privacy laws.

_____ _____
Signature Date

_____ _____
VOAOR Adult Day Services Representative/Witness Date

Revocation: I do hereby revoke my agreement to release or exchange any and all of the aforementioned information signified on this document. Volunteers of America Oregon will not withhold treatment or services for refusal to sign this form.

_____ _____
Signature Date

_____ _____
VOAOR Adult Day Services Representative/Witness Date