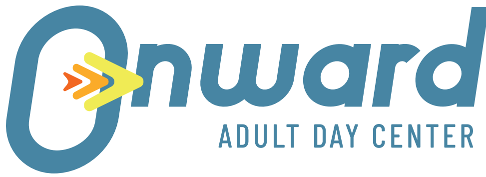

PARTICIPANT ENROLLMENT APPLICATION

Name of Person Completing this Form ______________________ Date ______________

If the participant is not the one completing this form, please describe the relationship you have with the participant:

☐ Parent/Guardian ☐ Spouse ☐ Friend ☐ Other, please describe: ______________________

How did you hear about Onward Adult Day Center: ☐ Facebook ☐ Website ☐ Drove by Building ☐ Online Search ☐ Word of Mouth ☐ Referral: ______________________ ☐ Other: ______________

PARTICIPANT INFORMATION

Name (first, middle, last) ______________________ Prefers to be Called ______________

Street Address ______________________ City ______________ State ______ Zip ______

County ______________________ Social Security Number ______________________

Phone ______________________ Email ______________________

Date of Birth: ______________________ Age: ______________ Sex: ☐ Male ☐ Female

Current Living Arrangement: ____

I am my own guardian: ☐ Yes ☐ No If no, name of POA for healthcare: ______________________

Is the POA activated? ☐ Yes ☐ No DNR activated: ☐ Yes ☐ No *NOTE: If activated, OADC needs a copy of form.*

If applicable, Referring or Coordinating Agency: ______________________________________

Case Manager Name: ______________________ Case Manager Phone: ______________________

REPRESENTATIVE INFORMATION

Name (first, middle, last) ______________________ Relationship to Applicant ______________

Street Address ______________________ City ______________ State ______ Zip ______

Phone ______________________ Email ______________________

EMERGENCY CONTACT

If different from Representative, list an emergency contact:

Name (first, middle, last) ______________________ Phone ______________________

Relationship to Participant: ______________________

PHYSICIAN INFORMATION

Name ______________________ Name of Hospital ______________________

Phone ______________________ Email ______________________

Street Address ______________________ City ______________________ State ________ Zip ________

MEDICATION

List medication + dose taken between 7:30am-5pm. Attach additional sheet if needed.

1) ______________________

2) ______________________

3) ______________________

4) ______________________

5) ______________________

NOTE: Please bring Physicians Orders and List of Side Effects for all medications to your meeting.

PARTICIPANT QUESTIONNAIRE

Are you currently attending a day center/program? ☐ Yes ☐ No

If yes, please describe frequency and provided services: ______________________

____

Are you currently receiving 1:1 caregiver support during the hours of 7:30am-5pm? ☐ Yes ☐ No

If yes, would you plan on having them assist here? (They can join the family too!) ☐ Yes ☐ No

List your medical condition(s)/diagnoses: ______________________

____

____

List your known allergies, if applicable: ______________________

____

____

Do any allergies require an Epi-Pen? ☐ Yes ☐ No If yes, which allergies? ______________________

Do you have any dietary restrictions or needs? ☐ Yes ☐ No If yes, please explain: ______________________

____

Are you a choking hazard? ☐ Yes ☐ No If yes, please explain: ______________________

____

Do you have seizures? ☐ Yes ☐ No If yes, how frequently? ______________________

Type of seizure? ______________________ Do you know before it happens? ______________________

Seizure Protocol: ______________________

____

General description of Participant's way of communication: ______________________

____

General description of Participant's ability to feed/eat: ______________________

____

General description of Participant's functional mobility: ______________________

____

General description of Participant's toileting ability: ______________________

____

General description of Participant's sensory processing: ______________________

____

General description of Participant's behavioral tendencies: ______________________

____

List any coping mechanisms/tools that better a situation: ______________________

____

General description of Participant's 'typical day': ______________________

____

Assistive Devices/Aids (check if any of the following mechanical aids are used/needed):

☐ Braces ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Communication Device ☐ Glasses/Contacts

☐ Hearing Aid(s) ☐ Other: ______________________

ONWARD ADULT DAY CENTER FOCUSED QUESTIONNAIRE

List a few goals, short-term or long-term, that you hope Onward Adult Day Center can focus on, play a role in, and assist with:

1) ____

____

2) ____

____

3) ____

____

At this time, OADC does not offer transportation to and from the center, but it is a goal of ours for the future! Would you like OADC to provide you with transportation service options? ☐ Yes ☐ No

TENTATIVE SCHEDULE?

Please include tentative days of the week (Monday-Friday) and hours (between 7:30 am–5 pm) Onward Adult Day Center can be in service to you:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
☐ FULL DAY	☐ FULL DAY	☐ FULL DAY	☐ FULL DAY	☐ FULL DAY
☐ HALF DAY AM	☐ HALF DAY AM	☐ HALF DAY AM	☐ HALF DAY AM	☐ HALF DAY AM
☐ HALF DAY PM	☐ HALF DAY PM	☐ HALF DAY PM	☐ HALF DAY PM	☐ HALF DAY PM

HOURS OF OPERATION: 7:30 AM–5 PM

Programming: 9–11:15 am ▪ Lunch/Transition ▪ Programming: 1–3:15 pm

Check any areas of interest for programming:

☐ Life Skills
☐ Cooking/Baking
☐ Around the World
☐ Social Skills
☐ Gross Motor Games
☐ Yoga
☐ Arts n' Crafts
☐ Exercise
☐ Writing & Poetry
☐ Book Club
☐ Dance & Movement
☐ Drama Club/Theater
☐ Board Games
☐ Sensory
☐ Music Exploration
☐ Computer & Technology
☐ Gardening/Outside Exploration
☐ Woodworking
☐ Brain Games
☐ All About Animals
☐ National Sports
☐ Other: ______________________________