



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-4:30pm. 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-4:30pm? 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) _____

TENTATIVE SCHEDULE?

Please include tentative days of the week (Monday-Friday) and hours (between 7:30 am-4:30 pm) Onward Adult Day Center can be in service to you:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
<input type="checkbox"/> FULL DAY	<input type="checkbox"/> FULL DAY	<input type="checkbox"/> FULL DAY	<input type="checkbox"/> FULL DAY	<input type="checkbox"/> FULL DAY
<input type="checkbox"/> HALF DAY AM	<input type="checkbox"/> HALF DAY AM	<input type="checkbox"/> HALF DAY AM	<input type="checkbox"/> HALF DAY AM	<input type="checkbox"/> HALF DAY AM
<input type="checkbox"/> HALF DAY PM	<input type="checkbox"/> HALF DAY PM	<input type="checkbox"/> HALF DAY PM	<input type="checkbox"/> HALF DAY PM	<input type="checkbox"/> HALF DAY PM

HOURS OF OPERATION: 7:30 AM-4:30 PM

Programming: 9-11:15 am ■ Lunch/Transition ■ Programming: 1-3:15 pm

Check any areas of interest for programming:

- | | | |
|--|---|--|
| <input type="checkbox"/> Life Skills | <input type="checkbox"/> Exercise | <input type="checkbox"/> Music Exploration |
| <input type="checkbox"/> Cooking/Baking | <input type="checkbox"/> Writing & Poetry | <input type="checkbox"/> Computer & Technology |
| <input type="checkbox"/> Around the World | <input type="checkbox"/> Book Club | <input type="checkbox"/> Gardening/Outside Exploration |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> Dance & Movement | <input type="checkbox"/> Woodworking |
| <input type="checkbox"/> Gross Motor Games | <input type="checkbox"/> Drama Club/Theater | <input type="checkbox"/> Brain Games |
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Board Games | <input type="checkbox"/> All About Animals |
| <input type="checkbox"/> Arts n' Crafts | <input type="checkbox"/> Sensory | <input type="checkbox"/> National Sports |
| <input type="checkbox"/> Other: _____ | | |