MemoryLane
CARE SERVICES

Dear Caregiver,

Thank you for expressing an interest in the Adult Day Center. We have enclosed several forms.

1. The healthcare provider form should be filled out completely by the physician or other healthcare provider, including a diagnosis of dementia for the person who will be attending. It should also indicate a negative TB test that has been done within the past year (skin test, blood test, or a negative chest x-ray). The healthcare provider's office may fax the completed form to us or you may mail it.

2. Or, if you prefer that we reach out to the physician or healthcare provider for you, please fill out the release of information form, sign it, and return. Be sure to indicate the phone and fax number we should call.

3. Please complete the cost share application, making sure to sign and date on the back of the form.

As soon as all the completed forms have been received, we will call to set an intake appointment. The appointment is usually about one to one and a half hours to complete.

We look forward to meeting you. Please feel free to contact us at 419-720-4940 with any questions or if we may provide any other support.

Sincerely,

Gale Begley
Activity Director

Cheryl Conley, MA, LSW
Social Services Director

# HEALTHCARE PROVIDER FORM

## INITIAL MEDICAL FORM/90 DAY UPDATE/STANDING ORDER REQUEST

MemoryLane CARE SERVICES

**Adult Day Services Program**
**2500 North Reynolds Road**
**Toledo, Ohio 43615**
**P: 419-720-4940 F: 419-720-4941**
**www.memorylanecareservices.org**

**Patient Name: _____ Date of Birth_____**

| | |
|---|---|
| Physician/Healthcare Provider: | |
| Physician/Healthcare Provider Address: | |
| Phone Number: | Fax Number: |

**Has the Applicant been diagnosed with memory impairment?** (Check one) ____ Yes ____ No

What was the diagnosis? _____ Date of Diagnosis _____

**Tuberculosis Screening (Negative test result must be within the last year).**

Date of Negative TB Result with documentation: ____ Skin Test or, ___ Chest X-Ray or, ___ QuantiFERON Blood Test

**Standing Orders:**

- Tylenol 325 mg 1-2 q 4hr prn, po for pain or fever.
- Ibuprofen 200 mg 1-2 tablets q 4-6 hr. prn po for pain or fever.
- Aerosol treatment as requested by physician order.
- Baby Aspirin for severe chest pain
- Tums
- Pepto Bismol

| | | |
|---|---|---|
| All Medications Listed Are Approved? | □ YES | □ NO |
| Are medication(s) administration or other service to be provided at Center? | □ YES | □ NO |
| Nurse May Administer Medications if Client is unable at Center? | □ YES | □ NO |

**Other Orders (please specify):** **** If yes, please attach list of medications and orders****

□ Therapeutic meals:
□ Nursing services:
□ Nutritional consultation:
□ Physical Therapy:
□ Occupational Therapy:
□ Speech Therapy:
□ Other:

Are there any physical limitations or medical considerations that would restrict applicant from attending an Adult Day Center ____ Yes ____ No *If yes, please specify*

Special Equipment?

**Are there Advanced Directives (DPOA) for healthcare**? _____ Yes ____ NO
DNR? _____ Yes _____ *No If yes, please attach a copy* Living Will? _____ Yes _____ No

****PLEASE INCLUDE THE LAST OFFICE NOTE AND H&P, CURRENT MEDICATION LIST, NEGATIVE TB RESULT, AND ALLERGIES (DRUG, FOOD, ENVIRONMENTAL, AND DIETARY) ****

**Healthcare Provider Signature**: **Date**:

***For Office Use Only***: *Above received and reviewed by MemoryLane Care Services Staff Nurse*
Staff Nurse Signature: Date:

**MEMORYLANE CARE SERVICES**
**HEALTHCARE PROVIDER AUTHORIZATION TO RELEASE INFORMATION/EXCHANGE CONFIDENTIAL INFORMATION**

I, _____ authorize and agree for

Name of Healthcare Provider: _____

Address: _____

Telephone Number: _____

Fax Number: _____

☐ to release information

☐ to obtain information

☐ to exchange with

on _____
(printed name of individual attending adult day services)

to coordinate services for participation in the adult day center program, I request:

Information to be disclosed: **Current History and Physical and Current Medication List**

_____

Purpose of disclosure: **To coordinate and provide services at MemoryLane Care Services Adult day Center**

_____

Information will be disclosed to: **MemoryLane Care Services**

_____

I understand I have the right to refuse this form, and that I may revoke my consent at any time.

_____ _____
Signature Date

_____
Printed Name

This information will not be used for any other reason than the purpose stated above

This authorization and release expire on **December 31,2020**

Staff member requesting release: **Gale Begley** **1/1/2020**
Staff Printed Name/Signature Date

**ADULT DAY CENTER**
**PARTICIPANT COST SHARE ASSISTANCE APPLICATION**

MemoryLane Care Services Adult Day Center is funded in part through the Senior Services Levy for older residents of Lucas County and State of Ohio Alzheimer's Respite Funds by a grant from the Area Office on Aging.

## PROGRAM PARTICIPANT INFORMATION

Name _____

Address_____

City_____State_____Zip_____

Phone Number: _____

Date of Birth _____ Marital Status: ___Single ___Married __ Widowed __ Divorced

## MONTHLY INCOME

Please indicate below the participant's monthly income from all sources including but not limited to income received from the following:

- Social Security
- Annuities
- Disability/sick benefits
- Interest
- Dividends
- Retirement benefits
- Public assistance
- Estate/trust fund payments
- IRA Income
- Farm income
- Veterans benefits
- Pensions
- Rental property income
- Wages/Salary

| Source of Income | Amount |
|---|---|
| | |
| | |
| | |
| | |
| | |

**TOTAL INDIVIDUAL MONTHLY INCOME** _____

Insurance Provider: _____

Group Number: _____

Policy Number: _____

Medicare Number: _____

Social Security #: _____

To the best of my knowledge, the information provided above is true, accurate and complete disclosure of total income. I understand that these programs are supported, in part, by contributions from participants. If there is a significant change in any of the information provided, it will by my responsibility to notify MemoryLane Care Services.

_____ _____ _____

Signature of person providing information Relationship Date

Printed Name: _____ Phone Number: _____

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***For office use only***

| **Monthly Income** | **Client** |
|---|---|
| | |

**Client is eligible for cost share assistance: _____*Yes*** **_____*No***

**Full day rate*:* _____ Half day rate*:* _____**

**Cost Share Assistance Amount*:*_____**

**Transportation rate: _____**

**MemoryLane Care Services|**
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**Phone: (419) 720-4940 Fax: (419) 720-4941**