



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

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:	
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Baby Aspirin for severe chest pain • Tums • Pepto Bismol
All Medications Listed Are Approved?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are medication(s) administration or other service to be provided at Center?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nurse May Administer Medications if Client is unable at Center?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Orders (please specify): ** If yes, please attach list of medications <u>and</u> orders**	
<input type="checkbox"/> Therapeutic meals:	<input type="checkbox"/> Occupational Therapy:
<input type="checkbox"/> Nursing services:	<input type="checkbox"/> Speech Therapy:
<input type="checkbox"/> Nutritional consultation:	<input type="checkbox"/> Other:
<input type="checkbox"/> Physical Therapy:	
Are there any physical limitations or medical considerations that would restrict applicant from attending an Adult Day Center ___ Yes ___ No <i>If yes, please specify</i>	
Special Equipment?	
Are there Advanced Directives (DPOA) for healthcare? ___ Yes ___ NO	
DNR? ___ Yes ___ No <i>If yes, please attach a copy</i> 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:	
Staff Nurse Signature:	<i>For Office Use Only: Above received and reviewed by MemoryLane Care Services Staff Nurse</i>
	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 **This release expires 1 year from the date signed above**

Staff member requesting release: _____
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 be my responsibility to notify MemoryLane Care Services.

Signature of person providing information

Relationship

Date

Printed Name: _____ Phone Number: _____

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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