

Academy & Adult Day Training Application

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Applicant’s full name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_\_\_

Medicaid#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information About Applicant**

Why are you interested in coming to this program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous experience in a Day program? \_\_\_Yes \_\_\_No If yes, where and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any personal concerns or information that may impact on our provision of care to this participant? No Yes If Yes, Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Care Information**

Please list the names of two persons who may be contacted in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name & Relationship to Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Address Telephone / Cell Phone Number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Name Relationship to Applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Address Telephone / Cell Phone Number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Touching Heart’s Academy & Adult Day Training Application for Enrollment Services and Agreements**

Transportation will be provided by: Relative or Friend Yes/No Please provide name, address and telephone number if yes.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Touching Heart’s Transportation: Y/N. If so, please list drop off and

Days of Attendance: (Please Circle) M T W Th F Arrival Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Departure Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Special dietary needs, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Attach a copy of the doctor's orders if on a therapeutic diet) Supportive devices used by applicant:**

1. This participant does not require a POA, may make his/her own medical or other decisions, and may sign for his/herself legally. Yes/No. If yes, please list information below.
2. Participant (named below) has a Power of Attorney or legal guardian (POA document shown)  Name of POA/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # of POA/guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Participant has a DNR order. Yes or No. If yes, please provide documents. I will provide the day program with an original copy.

The validated staff will administer medications, if needed, as prescribed. I will provide these medications in the containers as dispensed with their proper labeling as per state requirements. All medications will be locked and distributed at time prescribed. Yes or No

It is the responsibility of the participant and/or responsible party to notify the Center of any changes in medication, health conditions, etc. Yes or NO

I have received a copy of my Participants Rights in my enrollment packet. Yes or No

**Touching Heart’s Academy & Adult Day Training Enrollment Application. Please check the boxes and circle Yes or No to acknowledge you completely understand. If you circle no, please STOP this application process and call our office at 352-589-1942**

I agree to adhere to the program requirements by having an annual physical and tuberculin skin test or physician verification of being free of communicable disease. The results will be maintained as a part of my confidential program health records. Yes or No?

I hereby authorize/ not authorize the Touching Heart’s Adult Day Training to use my pictures, video, slides or tape recording of me for publicity, our in-house photo album and/or news releases relating to the Touching Heart’s Adult Day Training Yes or No?

I hereby authorize Touching Heart’s Adult Day Training to take photographs and create a “scent- pack” to be confidentially maintained and used only for identification purposes. I authorize my name with these forms of identification. Yes or No?

Touching Heart’s Adult Day Training has my permission to transport this participant on field trips and/or to and from the facility as needed. I will be notified by staff of each field trip. Yes or No?

All items brought to the center must be marked. Touching Heart’s Adult Day Training will not be held responsible for missing or lost items.

If emergency medical care becomes necessary, I give permission for any treatment the physician deems necessary. Yes or No?

The day program's policies have been explained to me and I have been given a copy of them and agree to abide by them. Yes or No? If not, please contact us via email or phone.

I acknowledge that I have received Touching Heart’s Adult Day Training’s Notice of Privacy Practices. I understand that the notice and disclosures of my protected health information by Touching Heart’s Adult Day Training informs me of rights and respect of my protected health information. A signed authorization and specifics regarding the release of information will be signed at each information request, when indicated by law.

Applicant Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOUCHING HEART’S ADULT DAY TRAINING MEDICINE LIST/WAIVER**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| If  Taken at the Program | Times Given at Program | Name of Medication | Dosage | Frequency | Route | Notes |
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|  |  | Use back if necessary |  |  |  |  |

To be prepared for the emergencies that can and do happen, please list below all medications being taken either at the Center or at home by the participant. This will provide the rescue squad with the vital medical information that is necessary to administer proper treatment. It is important that the staff at the Center be given in writing any changes in medication to keep our records current.

I hereby authorize the personnel of Touching Heart’s to administer the medicine(s) listed below. In doing so, I hereby release said program, its officers, staff and personnel, from any and all liability that might arise as a result of the medication being administered and hereby waive any action which I may have as a result of the medication being administered. I will be notified when the medicine supply is low. Furthermore, I release the fore said from any and all liability that might arise as a result of said medication not being administered because the supply was not replenished.

Over-the-counter medication(s) ordered by Physician: (Physician’s order with dosage & instructions are required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Policy:**

State regulations prohibit administering any medication not in the original container from the doctor or pharmacy. STATE OF FLORIDA LAW under medications kept by the program shall be in containers in which they were dispensed from the pharmacy. 65-G, the containers shall be clearly labeled with the participant's full name, the name and strength of the medicine, and dosage and instructions for administration. Only medications that meet this stated criterion will be given. Most pharmacies will give two containers if asked. Pills brought to the center in envelopes, pills boxes or other containers not meeting the above description cannot be given. Touching Heart’s must have any over the counter medications be accompanied by a physician’s order when dispensed at the program.

With everyone's safety in mind, it is necessary to strictly comply with this policy. It is not intended to be a hardship on anyone. Thank you for your cooperation.

Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Medical POA’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_