MANAWA LEA HEALTH SERVICES

Application Date ____/____/____ **Start Date** ____/____/____

CONSUMER PROFILE

Name:_____ Sex: ❑ M ❑ F DOB:____/____/____

Residential Provider: _____

Address:_____ Phone:_____

Medicare #:_____Medicaid #:_____S.S. #:_____ Other:_____

Citizenship:_____ Language spoken / understood:_____

Case Manager:_____ Unit:_____ Phone:_____

Address: _____

Mother's Name:_____ Phone:_____

Address: _____

Father's Name:_____ Phone:_____

Address: _____

Legal Guardian:_____ Phone:_____

Address: _____

EMERGENCY INFORMATION

Person to notify in the event of an emergency (List at least 2)

Name:_____ Phone:_____

Name:_____ Phone:_____

Physician's Name:_____ Phone:_____

Address: _____

Other Significant Specialist: _____

Additional Emergency Medical Instructions: _____

HISTORICAL INFORMATION

Previous Residence:_____ Dates:_____
Previous Residence:_____ Dates:_____
Previous Day Program:_____ Dates:_____
Work History:_____ Dates:_____

MEDICAL INFORMATION

Diagnosis:_____
Height:_____Weight:_____ Last Physical Exam Date:_____
Allergies:_____

Seizures: Describe Type:_____
Frequency:_____
Special Seizure Instructions:_____
Vision:_____ Hearing:_____
Current Medications: (List all and specify those to be given at day program)-

Dietary Needs: _____

Special Equipment Needs: (feeding, mobility, postural supports, specify)-

Significant Surgery / Diseases / Major Illness / History: (Specify type and date)-

Special Medical Needs: (NG/G-Tube, decubitis care, specify)-

Medical / Special Needs Instructions:

Upon acceptance and prior to attendance, applicant must provide a written medical assessment performed by, or under the supervision of, a licensed physician, which is not more than a year old when obtained. The medical assessment shall provide the following:

1. A record of any infectious or contagious diseases or any medical condition which would preclude care of the person by Manawa Lea.
2. A tuberculosis clearance.
3. Identification of the consumers special needs.
4. Identification of any prescribed medications being taken by the consumer.

Manawa Lea retains the authority to require the applicant to obtain a more current medical assessment, if such an assessment is necessary to best verify the appropriateness of the applicant for Manawa Lea Adult Day Health services.

SKILLS ASSESSMENT

SELF-HELP

Eating Skills: Independent Partial Assist Hand-over-Hand Dependent
Special Equipment:_____
Special Needs:_____

Dressing Skills: Independent Partial Assist Hand-over-Hand Dependent
Special Equipment:_____
Special Needs:_____

Toileting Skills: Independent Partial Assist Hand-over-Hand Dependent
Special Equipment:_____
Special Needs:_____

Grooming Skills: Independent Partial Assist Hand-over-Hand Dependent
Special Equipment:_____
Special Needs:_____

Communication Skills: (Specify methods: gestures, pictures, sign language, facial expressions, eye movements, augmentative communication devices, etc.)

_____
_____

INDEPENDENT LIVING SKILLS

Household (bed-making, washing dishes, dusting, etc.)
Independent Partial Assist Hand-over-Hand Dependent
Mobility Independent Partial Assist Hand-over-Hand Dependent
Special Devices / Aids:_____
Uses public transportation systems: Independent Partial Assist Full Assist

Money Use/Shopping: *(Indicate Yes or No)*
Makes Purchases: Independently With Partial Assist With Full Assistance
Names Coins:_____ Identifies Coins:_____ Names Bills:_____ Identifies Bills:_____
Adds money to produce specific amount: Counts out change:_____ Uses Banks:_____

Cognitive: *(Indicate Yes or No)*
Understands: Simple Instructions _____ Complex Instructions _____
Counts:_____ Reads (explain):_____

Writes (explain)_____
Knows Personal Information:_____ Recognizes called name:_____
Discriminates: Shapes_____ Colors_____ Knows "same"_____ Knows "different"_____
Other Cognitive Skills / Abilities: _____
_____
_____
_____

MOTOR SKILLS

(Indicate Yes, No or Level of Ability)

Extends Arms_____ Grasps with Hands_____ Sitting Balance_____

Rolls from side to side_____ Lower extremity weightbearing_____

Mobility (specify)_____

_____

_____

BEHAVIORAL NEEDS

Behavioral Problems_____

_____

Programs used to manage behavior _____

_____

Reinforcers_____

_____

_____

RECREATION and LEISURE SKILLS

Likes_____

Dislikes_____

Responses to Socialization_____

Other Social / Recreational Information_____

_____

_____

A current Case Manager Social Summary is required, and must be attached for completion of this application.

Signature of Applicant: _____

Witness: _____

AGENCY USE ONLY

_____ Medical Assesment

_____ Interview completed by: _____

Decision Regarding Acceptance: _____