SAINT MARY HOME
PART OF THE MERCY COMMUNITY

ADULT DAY CENTER

Phone: 860.570.8234

- Hours: Monday through Friday; 8:00 a.m. – 4:00 p.m.
- Door-to-door transportation provided
- Located in the Saint Mary Home Auditorium
- Daily hot meal with soup, salad and sandwiches
- Outdoor patio area
- Monthly calendars highlight special events:
    - Breakfast Club
    - Monthly Birthday Parties
    - Cognitive games
    - Theme Meals
    - Daily physical activities
    - Weekly exercise class
- Large-screen TV
- On-site hairdresser available

To Start:

- Copy of recent medical history and physical, signed by MD
- Completed information packet

A Medical Model

- Monthly wellness checks: weight, blood pressure, pulse
- Respiratory assessment, as needed
- Treatments
- Glucometer monitoring
- Assistance with weekly showers
- Assistance with medications:
    - Need to be in original containers
    - Must have doctor's order
    - Annual flu vaccine
- On-site monthly Podiatry Clinic
- Assistance with meals:
    - Dietitian available for any special needs
- On-site access to physical, occupational or speech therapy

SAINT MARY HOME
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Adult Day Center/Frances Warde Tower Apartments
2021 Albany Avenue, West Hartford, CT 06117
860.570.8200

APPLICATION FOR ADMISSION

Last Name:	First Name:			Middle/Maiden Name:	
Address:	City:	State:	Zip:	Phone:	
Sex:	DOB:	Age:	Marital Status:	Religion:	Place of Worship:
Birthplace:	Citizen of:	Address of Place of Worship:			
Spouse's Name:	Father's Name:	Mother's Maiden Name:			
SSN:	Medicare No.:	Medicare No.:			
Blue Cross/Blue Shield No.:	Other Insurance & Policy No.:				
Veteran: ☐ Yes ☐ No Spouse of Veteran: ☐ Yes ☐ No	Branch of Service:	Service No.:			
Physician's Name:	Phone:				
Physician's Address:	City:	State:	Zip:		
Pharmacy Preference:	Hospital Preference:				
Ambulance Preference:	Funeral Home Preference:				

Person(s) to be Notified

Name and Relationship	Address:	Home Phone:	Business Phone:

Who has Power of Attorney (POA), Conservator of Person and/or Estate?

Name and relationship:			
Address:			
Home Phone:	Business Phone:		
Billing Contact Name:			
Address:	City:	State:	Zip:
Home Phone:	Business Phone:		

Where have you lived for most of your life? _____

With whom are you living now? _____ For how long? _____

What is your highest achieved level of education? _____

What was your occupation before retirement? _____ When did you retire? _____

What are your pursuits of leisure and community involvement? _____

_____

_____

Have you ever lived in a skilled nursing facility before? ☐ Yes ☐ No

If not, in what ways do you need assistance? _____

Please give dates and nature of any major illnesses and/or operations: _____

_____

_____

_____

Have you ever been treated for: ☐ Alcohol abuse ☐ Drug abuse ☐ Emotional problems

If so, please state where and when: _____

Do you have you a current primary or secondary mental health diagnosis? _____

If so, briefly describe and list date(s) of onset: _____

_____

Have you a history of cognitive impairment? ☐ Yes ☐ No

If so, describe briefly and list the date(s) of onset: _____

_____

Reason for application/current problem areas: _____

_____

_____

_____

_____

I certify that all statements above are accurate to the best of my knowledge.

Print Name: _____

Signature of Applicant or Responsible Party: _____

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2021 Albany Avenue, West Hartford, CT 06117
860.570.8200

PHYSICAL EXAMINATION

Last Name: _____ First Name: _____ Date of Birth _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Level of Care Certified for: ☐ The Frances Warde Towers Apartments ☐ Adult Day Center

Primary Diagnosis: _____

_____

Medical History: (including prior surgery and hospitalization): _____

_____

Physical Examination:

B.P.: _____ Apical Rate: _____ Resp.: _____ Height: _____ Weight: _____

CHECK	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS BELOW:
Skin/hair/nails			
HEENT			
Breasts			
Lungs			
Heart			
Periph. Vessels			
Abdomen			
Rectal			
Genitalia			
Extremities			
Musculoskeletal			
Neurological			

Hearing: _____ Left: _____ Right: _____

Vision: _____ Left: _____ Right: _____

Pelvic: _____ Pap within two years, if under 60 years: _____

Mental status: ☐ Alert ☐ Cognitive Deficit ☐ Confused

Behavior: ☐ Normal ☐ Sociable ☐ Withdrawn ☐ Alcoholic ☐ Noisy ☐ Belligerent

Continent: Bowel: _____ ☐ Yes ☐ No Bladder: _____ ☐ Yes ☐ No

Can resident/client receive flu vaccine annually? ☐ Yes ☐ No Can resident/client receive yearly PPD screening? ☐ Yes ☐ No

Does resident/client have any exercise restrictions? ☐ Yes ☐ No

Resident/client:_____

Laboratory Findings Date of tests:_____

Blood: Het:_____ Hgb:_____ FBS:_____ Bun: _____ Indices:_____

Urine: Albumin:_____ Sugar:_____ Microscopic:_____

Syphilis: VDRL (within 10 years): _____

CXR or TB Screening:_____ Tet/Dipth. Toxoid Imm. (within 10 years):_____

Tests (within 5 years): _____

Tonometry: _____

Screening audiometry (persons without aid): _____

History of cognitive impairment (when/where): _____

_____

FUNCTIONAL CAPACITY

Requires the use of: No mechanical device:_____ Cane: _____ Bed Chair:_____

Walker: _____ Bedridden:_____ Crutches: _____

Is resident/client physically and mentally capable of making his or her way without assistance to a place of safety outside of the building? ☐ Yes ☐ No

Allergies (including medications):_____

_____

Diet:_____

Rehabilitation Potential (please specify):

Physical: _____

Mental: _____

Please list medications that resident/client is currently taking (including dosage, frequency, and number of refills per prescription):

_____ _____ ----------

_____ _____ ----------

_____ _____ ----------

_____ _____ ----------

Is resident/client capable of taking his or her own medication(s)? ☐ Yes ☐ No

Is resident/client ambulatory? ☐ Yes ☐ No Does resident/client require 24-hour nursing care? ☐ Yes ☐ No

Are you the family physician? ☐ Yes ☐ No Will you continue as the family physician here? ☐ Yes ☐ No

Additional comments: _____

_____

Physician's Signature: _____ Date: _____

SAINT MARY HOME
PART OF THE MERCY COMMUNITY

Risk Assessment Questionnaire for Tuberculosis Exposure

1. Was the participant born outside of the U.S.A.? Yes _____ No_____

   *(If the participant was born in any of the countries in the attached list a *TST or *IGRA should be performed. For anyone with a previous false positive, a chest x-ray should be performed.)*

2. Has the participant traveled outside of the U.S.A.? Yes_____ No_____

   (If the participant has traveled to any of the listed countries, stayed for more than one week, interacted with the local population, including local family and friends, then a TST or IGRA should be performed. After the evaluation, testing for possible signs and symptoms of Tuberculosis (TB) disease or exposure to a person with contagious TB disease can take place eight to 10 weeks after return to the U.S.A.)

3. Has the participant been exposed to anyone with TB disease? Yes _____ No_____

   (If yes, determine whether the person has TB disease or a latent TB infection, when the exposure occurred, and the nature of the contact with the source of the exposure. If it is confirmed that the participant has known or suspected TB disease, a TST or IGRA should be performed.)

4. Does the participant have close contact with someone with a positive
   TST or IGRA? Yes _____ No_____

   (If yes, see previous question for follow up information needed.)

5. Does the participant live with anyone who has been in jail or prison, a shelter,
   who injects illegal drugs or who has HIV? *Yes*_____ *No*_____

   (If yes, then a TST or IGRA should be performed.)

6. Has the participant eaten unpasteurized cheese from Mexico or Central America since his or her last
   TST or IGRA? *Yes*_____ *No*_____

   (If yes, a TST or IGRA should be performed.)

***TST-Tuberculin Skin Test**

***IGRA-Interferon Gamma-Release Assay (blood test)**

TB Symptom Screen

1. Have you had a cough for two to four weeks duration? Yes_____ No_____

2. Are you coughing up blood? Yes _____ No_____

3. Do you have a fever? Yes _____ No_____

4. Do you experience night sweats? Yes _____ No_____

5. Have you experienced unexplained weight loss? Yes _____ No_____

6. Are you experiencing unusual weakness or fatigue? Yes_____ No_____

If experiencing above symptoms, a TST or IGRA is recommended.

List of High Risk Tuberculosis Countries

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
China, Hong Kong Special Administrative Region
China, Macao Special Administrative Region
Colombia
Comoros
Congo
Cook Islands
Cote d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Montenegro
Montserrat
Morocco
Mozambique
Myanmar
Namibia
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The Former Yugoslav Republic of Macedonia
Timor Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Vietnam
Yemen
Zambia
Zimbabwe

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SAINT MARY HOME
PART OF THE MERCY COMMUNITY

ADULT DAY CENTER

CLIENT BILL OF RIGHTS

- You have the right to be treated with consideration, respect, dignity, and individuality.

- You have the right to participate in a program of services and activities that promote positive attitudes on one's usefulness and capabilities.

- Saint Mary Home Adult Day Center does not discriminate against any person for reasons of race, sex, color, religion, or national origin.

- You have the right to be encouraged and supported in maintaining your independence to the extent that conditions and circumstances permit and to be involved in programs or services designed to promote personal independence.

- You have the right to self-determination within the Adult Day Center setting, including opportunity to:

    - Participate in developing one's plan of services;
    - Decide whether to participate in any given activity; and
    - Be involved to the extent possible in program planning and operation.

- You have the right to be in an atmosphere of sincere interest and concern in which needed support and services are provided.

- You have the right to privacy and confidentiality.

- You have the right to grieve any decision with which you disagree. You may do so either by phone or in writing to the Director of the Adult Day Center. If you do not receive satisfaction, you should call or write to the Assistant Administrator of Saint Mary Home.

SAINT MARY HOME
PART OF THE MERCY COMMUNITY

JOINT NOTICE REGARDING THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

This notice is effective beginning April 14, 2003.

MERCY COMMUNITY HEALTH, INC. is a health care system located in West Hartford, CT. This notice applies to the use and disclosure of Protected Health Information (PHI) by the following health care providers who are part of the MERCY COMMUNITY HEALTH, INC. heath care systems: Saint Mary Home and The McAuley. This notice also applies to uses and disclosures of your PHI by the physicians and other practitioners who are part of the medical staff of Saint Mary Home and The McAuley. Your health information will be shared among all of the entities covered by the notice for treatment, payment, and health care operations purposes.

MERCY COMMUNITY HEALTH, INC. is required by law to maintain the privacy of PHI and to provide you with notice of its legal duties and privacy practices with respect to such information. MERCY COMMUNITY HEALTH, INC. will abide by the terms of the notice currently in effect; however, MERCY COMMUNITY HEALTH, INC. reserves the right to change the terms of this notice as well as make new provisions effective for all PHI maintained. If there is a change, MERCY COMMUNITY HEALTH, INC. will provide you with a new notice upon your request. In addition, a copy of this notice will be posted at all times in various conspicuous locations notifying you of the most recent update to this notice.

As a resident/client/patient of MERCY COMMUNITY HEALTH, INC., information about you must be used and disclosed to other parties for purposes of treatment, payment, and health care operations. These uses and disclosures do not require your consent and include, but are not limited to, a release of information contained in financial records, medical records, laboratory test results, medical history, treatment progress, or any other related information to:

SAINT MARY HOME
PART OF THE MERCY COMMUNITY

ADULT DAY CENTER

APPLICANT'S FINANCIAL INFORMATION
CONFIDENTIAL

Your own income:

Social Security	$ _____ /month	
Pension	$ _____ /month	Source_____
Annuity	$ _____ /month	Source_____
Interest	$ _____ /month	Source_____
Dividends	$ _____ month	Source_____
Trust	$ _____ /month	Source_____
Other	$ _____ /month	Source_____

Have you ever applied for Title XIX? No _____ Yes _____

If so, when? _____

Please list any debts, obligations, mortgages, etc. that may affect the above assets or income:

_____

_____

Person responsible for payment of bills:

Name: _____

Address: _____

_____

Phone:_____

SAINT MARY HOME
PART OF THE MERCY COMMUNITY

ADULT DAY CENTER

PERMISSION AND WAIVER AGREEMENT

Name of client: _____

My choice of physician is:_____

In case of an emergency, if my personal physician is not available, I grant Saint Mary Home permission to summon a competent physician. The physician obtained will bill me directly and Saint Mary Home will not be responsible for any part of the bill for such service.

_____ _____
Signature of Client or Responsible Party Date

My choice of pharmacist is: _____

In case of an emergency medication need and my pharmacist cannot be reached, I grant Saint Mary Home permission to secure medications for me. I will be responsible for full payment of drugs so obtained. I hereby give permission to the pharmacy to substitute generic drugs at a lower cost.

_____ _____
Signature of Client or Responsible Party Date

I hereby authorize Saint Mary Home to destroy, according to the recommended procedures, any excess or undesired prescription drugs which my physician decided I am no longer to use.

_____ _____
Signature of Client or Responsible Party Date

I have been advised of and have been given a written copy of the Adult Day Center Discharge Procedure.

_____ _____
Signature of Client or Responsible Party Date

I have been advised of and have been given a written copy of the Resident Bill of Rights of Saint Mary Home.

_____ _____
Signature of Client or Responsible Party Date

I hereby authorize Saint Mary Home to release medical information when Saint Mary Home deems that such a release of information is in the best interest of the client and is necessary for the execution of medical care and insurance coverage.

_____ _____
Signature of Client or Responsible Party Date

I hereby give permission for Saint Mary Home to provide transportation to and from home and on scheduled outings and trips. ☐ Yes ☐ No

_____ _____
Signature of Client or Responsible Party Date

I have been advised, in case of a life-threatening emergency, 911 will be called and I will be transported by ambulance to my hospital of choice and I will assume all costs for services.

_____ _____
Signature of Client or Responsible Party Date

I give permission for emergency first–aide to be administered at Saint Mary Home and on any outings or trips.

_____ _____
Signature of Client or Responsible Party Date

I hereby give permission for the Program nurse to administer medications and treatments as prescribed by my physician.

_____ _____
Signature of Client or Responsible Party Date

I hereby give permission for the Saint Mary Home Podiatrist to perform any necessary treatments, including maintenance care.

_____ _____
Signature of Client or Responsible Party Date

I, the undersigned, hereby agree to comply with the policies of Saint Mary Home. Furthermore, I hereby agree that Saint Mary Home shall charge me for the services rendered and treatment provided at the listed rates, and I hereby agree that I am responsible for any reasonable collection of fees from failure to make such payments.

_____ _____
Signature of Client or Responsible Party Date

SAINT MARY HOME
PART OF THE MERCY COMMUNITY

PRIVACY NOTICE ACKNOWLEDGMENT

I have been provided the Joint Notice Regarding Use and Disclosure of Protected Health Information by Mercy Community Health, Inc. I have read and understand the information contained in the notice. Any questions I may have had were answered to my satisfaction.

_____ _____
Resident/Client Name [PLEASE PRINT] Date

_____
Signature of Person/Personal Representative

If signed by the Personal Representative, please print name and describe the person's authority to make such an authorization:

_____ _____
Name [PLEASE PRINT] Description of Authority

If not signed by resident/client or Personal Representative, please document the Good Faith Efforts made and the reason that the acknowledgment was not signed.

_____

_____

_____

_____

_____

_____ _____
Signature of Designated Staff Member Date

SAINT MARY HOME
PART OF THE MERCY COMMUNITY

ADULT DAY CENTER

Policy No.: ADC-23

Department: Adult Day Center

Approval: Administrator 6/24/97
Exec. Committee _____

Subject: Discharge Policy

[ ] New [ ] Revised

[ ] No Change [ ] Deleted

POLICY

A client will be discharged from the Adult Day Center if the participation of that client in the program presents a threat or danger to self or others. A client will also be discharged from the program due to changes in need or functional status that would require more intensive care than is available.

PURPOSE

To assure that the client is in the appropriate level of care and is receiving the necessary professional services to meet increasing needs.

DISCHARGE PROCEDURE

1. Each client and family/caregiver will be informed of the discharge policy of the program upon admission.

2. If it is determined that a client has changes in needs or functional status that require more intensive care, the client will be discharged from the program.

3. Discharge planning will be an ongoing process with each client starting the day a client is admitted to the program.

4. If a client has a sudden change in condition which compromises participation in the program, or causes threat or danger to self or others, immediate discharge will occur.

Orig. Date: 8/25/94
Rev. Date: 12/10/14

The Mercy Community

THE McAULEY | SAINT MARY HOME

CONSENT AND RELEASE TO BE PHOTOGRAPHED, INTERVIEWED OR PUBLISHED

I, _____ hereby grant Mercy Community Health, Inc. and its affiliates permission to use my name, interview information, and any photographic portraits or video footage taken of me. I understand that Mercy Community Health, Inc.'s possible uses may include, but are not limited to, print and broadcast news: newspaper, magazines, radio, television, video, websites, and social media.

I understand that this consent allows Mercy Community Health, Inc. and its affiliates to copyright this material for use and re-use.

I have read the foregoing and fully understand the contents thereof. This consent and release shall be binding upon me and my heirs, legal representatives, and assigns.

Name: _____ Date: _____

(Please Print)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Signature of Person Providing Consent to be photographed, interviewed and published

Relationship of person named above if signing as a parent or legal guardian for a minor

Signature of Witness _____

Mercy Community Health, Inc. • 2021 Albany Avenue •West Hartford, CT 06117 • 860.570.8200
Saint Mary Home • The McAuley

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