



# Stepping Stones Adult Day Program

*McKee Medical Center*

## **Enrollment**

## SERVICES PROVIDED AND ADMISSION CRITERIA

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Stepping Stones Adult Day Program provides participants with an opportunity to socialize, build friendships, and enjoy stimulating activities in a safe environment. While participating in the program, the caregiver is able to experience respite time away from the responsibilities associated with caring for a loved one.

Stepping Stones Provides:

- Daily planned activities and one to one attention
- Individualized plan of care
- A nutritious lunch and snacks
- Basic nursing assessments and health monitoring
- A monthly family support group

Stepping Stones serves many types of clients with a variety of abilities and challenges. However, Stepping Stones does **reserve the right** to discontinue services for any of the following reasons: 1) Excessive wandering that endangers the safety of the participant or other participants and is not re-directable by staff members ; 2) Violence or aggression, whether inflicted on self or others; 3) Medical procedures/conditions that require skills beyond program capabilities; 4) Excessive physical requirements that cannot be met by the program staff. 5) Extreme behavior issues that require 1:1 care or consistently disrupt the program.

## ENROLLMENT PROCESS

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Upon calling Stepping Stones Adult Day Program, the interested party will be sent:

- An enrollment packet
- Advanced directive information
- Monthly activity calendar and menu
- Notice of Privacy Practices for Banner Health

Prior to enrolling, an assessment must be completed on all potential participants. This can be done by the potential participant visiting the program with a family member or an assessment can be completed by the program manager visiting in your home. This helps to ease anxiety for both participant and caregiver. At this time, the application will be explained by the Program Manager and the responsible party can address any concerns or questions at this time. The enrollment forms located in this packet must be completed prior to the first day of attendance, including the *Physician's Form*, which must be completed and sign by the participant's attending physician.

The Program Manager will contact the nurse to schedule an appointment for the basic nursing assessment. Information gathered from the enrollment packet, the caregiver & participant interview, as well as the nurse's assessment, will be utilized to develop a *Plan Of Care* to ensure the participant's individual needs are met while attending the program. This plan of care will be reviewed with staff, the participant, family, and the participant's physician for approval, and changes will be made as needed.



**DEMOGRAPHIC AND EMERGENCY INFORMATION**

**NAME** \_\_\_\_\_

last first m.i.

**ADDRESS** \_\_\_\_\_

street city zip

**PHONE NUMBER** \_\_\_\_\_

**BIRTHDATE** \_\_\_\_\_ **AGE** \_\_\_\_\_ **GENDER** M F

**PRIMARY PHYSICIAN** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**PHONE NUMBER** \_\_\_\_\_ **FAX** \_\_\_\_\_

**IN CASE OF EMERGENCY NOTIFY:**

**RESPONSIBLE PARTY**

1) **NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**PHONE NUMBERS** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_

2) **NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**PHONE NUMBERS** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_

**CONSENT**

	YES	NO
Photographs, DVD's, voice recordings or interviews, including the right to reproduce the negatives, film, or digital prints in the quantity needed for educational, marketing and advertising purposes		
Supervised trips away from the program site		

\_\_\_\_\_  
Signature of participant / responsible party

## **BILLING INFORMATION**

**PLEASE CHECK THE APPROPRIATE PAYMENT METHOD:**

**PRIVATE PAY** *(If bill is to be sent to other than the above listed address of participant, please list that name and address here)*

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**LONG TERM CARE INSURANCE** *(Please list, including policy #)*

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**MEDICAID** *(Please list case manager and Medicaid ID #)*

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**OTHER** *(Please list appropriate information)*

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## **ADVANCED DIRECTIVES**

**Please check what advanced directives apply:**

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

POWER OF ATTORNEY

SUBSTITUTE DECISION MAKER (MEDICAL PROXY)

GUARDIANSHIP

COLORADO DO NOT RESUSCITATE

NONE

***PLEASE BRING A COPY OF ANY ADVANCED DIRECTIVE(S) TO BE PUT ON FILE IN ORDER FOR A DO NOT RESUSCITATE ORDER TO BE HONORED, A SIGNED COPY BY THE PHYSICIAN MUST BE ON FILE.***

## PHYSICIAN'S FORM

**Participant:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

This page is to be completed by the physician before the first day of attendance

**Primary Diagnosis:**

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**Pertinent Medical History:**

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**Allergies** \_\_\_\_\_

**Restrictions**

\_\_\_ **Activity Restrictions?** \_\_\_\_\_

\_\_\_ **Diet Restrictions?** \_\_\_\_\_

**Medications** PLEASE LIST ONLY MEDICATIONS (INCLUDING OVER-THE-COUNTER)  
TO BE ADMINISTERED AT PROGRAM)

Medication	Purpose	Dose	Time

***I recommend Adult Day Services at Stepping Stones Adult Day Program.***

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**Signature of Physician**

**Date**

## **Activities of Daily Living**

Category	Level of Assistance *Circles which best describes	Comments
Toileting	*independent * needs reminding * requires moderate assistance * incontinent - needs assist. w/ changing pads	
Eating	*independent * needs reminding * needs food cut up * requires feeding	
Walking	* independent * needs assistance of another * uses walker / cane * uses wheelchair - needs assist. w/ transfers	
Medications	* independent * needs reminding * requires assistance to administer meds <u>**Please list ALL meds taken on the following sheet provided</u>	
Hearing	* able to hear with within normal limits * needs speaker to clarify or repeat * wears hearing aids * requires alternate methods of communication	
Vision	* able to see regular print * wears glasses * needs large print * requires assistance of others for safety	
Hygiene/ Grooming	* independent * needs reminders * requires assistance of others	



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## **SOCIAL HISTORY**

**Parents:** \_\_\_\_\_

**Siblings:** \_\_\_\_\_

\_\_\_\_\_

**Spouse:** \_\_\_\_\_

**Children:** \_\_\_\_\_

\_\_\_\_\_

**Grandchildren:** \_\_\_\_\_

\_\_\_\_\_

**Any additional family information:** \_\_\_\_\_

\_\_\_\_\_

**Education:** \_\_\_\_\_

\_\_\_\_\_

**Childhood residence** \_\_\_\_\_

\_\_\_\_\_

**Travel:** \_\_\_\_\_

\_\_\_\_\_

**Other significant life experiences:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Previous hobbies:** \_\_\_\_\_

\_\_\_\_\_

**Current interests / hobbies:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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***SERVICE AGREEMENT***

I have been orientated to the Stepping Stones Program, including a tour of the facility, and have been given written information regarding the policies, procedures, and services provided. I have received information regarding advanced directives and Notice of Privacy Practices for Banner Health

\_\_\_\_\_  
initial

Please select:

\_\_\_\_ a regular schedule of *(please circle)* M T W T F  
*(please circle)* Full days Half days

\_\_\_\_ a drop in schedule - a 24 hour notice is requested and can only be accommodated as space permits

\_\_\_\_\_ agrees to pay:

- half day rate of \$41 (5 hours or less)
- full day rate of \$51 (5+ hours)

I understand that if a participant is scheduled and does not attend, based on the attendance policy, I may be charged for that day of service.

\_\_\_\_\_  
date

\_\_\_\_\_  
Participant / Responsible Party

\_\_\_\_\_  
Stepping Stones ADP

***This form must be signed before the first day of attendance***