Stepping Stones
Adult Day Program
McKee Medical Center

Enrollment

SERVICES PROVIDED AND ADMISSION CRITERIA

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

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 extensive over the phone interview; 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 process will be explained by the Program Manager and the responsible party can address any concerns or questions. The enrollment forms located in this packet must be completed and signed prior to the first day of attendance, including the *Physician's Form.*

Once enrolled, the Program Manager will contact the nurse to schedule an appointment for the participant's 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.

Banner Health
McKee
Medical Center

Stepping Stones Adult Day Program Enrollment Form

Name of Participant: _____ **Gender:**_____
Phone: _____ **Date of Birth:** _____

Race/ Ethnicity: _____ **Primary Language:** _____

Retired: ☐ Yes ☐ No **Veteran**: ☐ Yes ☐ No **Farmer**: ☐ Yes ☐ No

Marriage/Relationship/Partnership status: _____

Participant Residency Information

Address:_____ **City:** _____ **State:** _____ **Zip:** _____

Billing Address (if different than above):_____**City:** _____**State:** _____

Zip: _____ **County:** _____ **Rural**: ☐ Yes ☐ No

Residence Type: ☐ Own ☐ Rent ☐ Family Member's Residence ☐ Care Facility ☐ Other

Number of People in Household: _____

Relationships (Ages): _____

In Case of Emergency/Responsibly Party Information

Responsible Party's Name: _____

Phone: _____ **Relationship:** _____

Address (if different than above):_____ **City:** _____ **State:** _____

Zip: _____ **County:** _____

Additional Emergency Contact Name:_____ **Phone:**_____

Medical Information

Primary Care Physician: _____ **Phone:** _____ **Fax:**_____

Address _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Diagnosis: _____

Hearing Aids: ☐ Yes ☐ No **Glasses/Contacts**: ☐ Yes ☐ No

Stepping Stones Program

Admittance Date _____ **# of Days/week:** _____ **Type of Days**: ☐ Full ☐ Half ☐ Drop In

Benefits & Insurance Information

Private Pay: ☐

Medicaid: ☐ Current Recipient

Medicaid ID Number: _____ Case Worker: _____

Other Insurance: ☐ Long Term Care Insurance

Policy **#:** _____

Gross Monthly Income Information

****Please give your estimated monthly income. You do NOT need to bring in verification for income amounts. This information is confidential and is used for Stepping Stones' funding and scholarship opportunities.***

Number of People in Household with Income: _____

Participant's Monthly Income Range: $_____

Spouse's Monthly Income Range: $_____

Caregiver/Family Member's Monthly Income Range: $_____

Other Income Information

Liquid Assets Amount $_____

Supplemental Security Income Recipient ☐ Yes ☐ No Policy #: _____

Other Benefits Received by Household Members :

☐ Supplemental Nutrition Assistance Program (SNAP)

☐ Temporary Assistance For Needy Families (TANF)

Advanced Directives

Advance Directive (Please check all that apply):

- ☐ **Durable Power of Attorney for Healthcare**
- ☐ **Power of Attorney**
- ☐ **Substitute Decision Maker (Medical Proxy)**
- ☐ **Guardianship**
- ☐ **Colorado Do Not Resuscitate (DNR)**
- ☐ **None**

***Please bring a copy of any Advanced Directive(s) to be placed on file**

****Please note, in order for *a Do Not Resuscitate Order to be honored*, a signed copy by the physician MUST be on file at Stepping Stones.**

Supervised Trips

Permission for supervised trips away from program: YES ☐ NO ☐

PATIENT ACKNOWLEDGEMENT

I certify that the information provided on this application is true and accurate to the best of my knowledge.

Participant/Responsible Party Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Banner Health Facilities do not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, ethnicity, religion, culture, language, socioeconomic status, sex, sexual orientation, gender identity or expression, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any BH program or activity, whether offered directly or through a contractor. Any individual who believes he/she has been subject to discrimination may file a Complaint under this policy.

Stepping Stones
Adult Day Program
McKee Medical Center

PHYSICIAN'S FORM

Participant: _____***DOB:***_____

Physician: _____

Primary Diagnosis:

_____

_____

_____

Pertinent Medical History:

_____

_____

Allergies _____

Restrictions

____ ***Activity Restrictions?***_____

____ ***Diet Restrictions?***_____

Medications ***PLEASE LIST ONLY MEDICATIONS TO BE ADMINISTERED BY STAFF WHILE PARTICIPANT IS ATTENDING PROGRAM***

Medication	Purpose	Dose	Time

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

_____

Signature of Physician ***Date***

Stepping Stones
Adult Day Program
McKee Medical Center

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 **Please list ALL meds taken on the following sheet provided	
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	

Stepping Stones
Adult Day Program
McKee Medical Center

SOCIAL HISTORY

Parents:_____

Siblings: _____

_____

Spouse:_____

Children:_____

_____

Grandchildren:_____

_____

Any additional family information:_____

_____

Education:_____

_____

Childhood residence_____

_____

Travel:_____

_____

Other significant life experiences:_____

_____

_____

_____

Previous hobbies:_____

_____

Current interests / hobbies:_____

_____

_____

Stepping Stones
Adult Day Program
McKee Medical Center

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, services provided and offered a copy of the enrollment forms. 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, Half, Prime Time**

____ 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 $46 (5 hours or less); full day rate of $56 (5+ hours) Prime Time rate of $40 (between the hours of 10-3); hourly-$15

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 Staff:_____

Enrollment forms must be signed prior to the first day of attendance