Admission Date:
___/___/_____

Edwards
Adult Day Center

# ADMISSION AGREEMENT

1. Edwards Adult Day Center (EADC) is open from 7:00 AM to 5:00 PM during weekdays. Participants who are covered by the Veterans Administration must stay a minimum of four (4) hours on their days of attendance. Medicaid participants must stay a minimum of six (6) hours on their days of attendance. Participants picked up after 5:00 p.m. will incur a $25.00 late fee and will be charged $10 for every 15 minutes or increments thereof. This fee is necessary to cover costs of staff and utilities required to operate the center after designated closing time.

2. Prior to enrollment, all participants are required to have a physical examination and a PPD Test within thirty days of initial admission. A physical must be done yearly thereafter. However, the PPD Test is only done at the time of admission.

3. Participants and their families must provide transportation to and from EADC, unless other means of transportation have been arranged with the EADC Van Service. EADC will inform the participant and their families of the EADC Van Service schedule of pick up and drop off times and any cancellations.

4. The participant or a family member will contact the EADC on the day prior to an unscheduled absence/attendance, if possible.

5. EADC agrees to notify a family member if the participant becomes ill. The family agrees to pick up the participant within one hour of notification. Participant will be isolated until picked up. If the participant has a fever and/or a contagious illness, please do not send them to the EADC facility. They must be fever free for twenty-four (24) hours before returning to EADC.

6. In case of a medical emergency, 911 will be called and Sovah Health - Martinsville will be utilized.

7. Services are provided in a protective environment and will include physical exercise, social interaction, mental stimulation, crafts, quiet times, and other activities. Participants will be encouraged to be as independent as possible and will be assisted as needed.

8. The food that will be provided at EADC is an AM and PM snack and a hot noon meal.

9. The EADC program receives funds under the Federal Older Americans Act. The Older Americans Act requires that all persons who receive services be given an opportunity to contribute to the cost of that service.
    a. Contributions are applied to the services for which the donation is made.
    b. No individual is denied a service(s) because he/she cannot or is not willing to contribute.
    c. If they wish to contribute, a cash box is placed in an area convenient to participants and caregivers for their use.
    d. The Administrative Assistant, using the bookkeeping procedures established for the program, handles receipt of all contributions.

e. The participant's right to privacy regarding contributions and all other information about the individual is protected by this established EADC Policy: Confidentiality, as required by the Department of Social Services, the licensing agent.

10. Participation in the program is limited to the changing needs of the participant and family. EADC will make recommendations for alternative services when EADC can no longer meet the needs of the participant.

11. If it becomes necessary to terminate a participant's attendance at EADC, two (2) weeks' written notice will be given. A new participant contract may be terminated after five (5) days of attendance if either party finds that conditions or services are substantially different to what were initially represented. EADC may terminate a contract if the participants:
    a. Conditions deteriorate, requiring more intensive care than the staff can provide.
    b. Conditions improved so that the structured and supervised setting of day care is no longer warranted.
    c. Behavior can no longer be accommodated in a group setting or the participant becomes totally disoriented.

12. A plan of discharge will be made by the EADC Executive Director in consultation with the participant's primary caregiver/family.

13. Services will be provided without discrimination regarding race, color, age, sex, national origin, marital status, physical or mental disability, so long as the prospective participant meets the criteria for enrollment, has completed the application process, and space is available in the EADC facility.

14. I understand that I am responsible for payment for services provided, unless some other source for payment has been secured (such as Medicaid, Veterans Administration, etc.).

15. I understand that I am responsible for reporting any changes regarding the participants insurance (such as their Medicaid Vendor changing, needing to be renewed, etc.) If there is no communication, EADC cannot determine if the participant has had any changes. This has caused EADC to bill incorrectly which can lead to financial hardship. Since this is happening more often, EADC requires that you report the change of insurance so that EADC can be billed correctly. If this report is not made, the participant/caregiver will be held accountable for the balance.

16. Private Pay Invoices will be sent out with a net fifteen (15) remit and a $20.00 late fee will be added to the invoice after fifteen (15) days of non-payment. Costs for Private Pay services are listed below and are due by the 15th of every month:
    a. Day Services – $75.00 (more than 4 hours)
    b. Half Day Service - $55.00 (less than 4 hours)
    c. Transportation - $12.00 per trip
    d. Hygiene Care - $25.00 per episode

**If a Caregiver is THIRTY (30) DAYS LATE IN PAYMENT, Edwards Adult Day Center has the right to deny services until the account is brought current.**

I HAVE READ AND ACCEPT THE CRITERIA FOR ENROLLMENT AND I AM AWARE OF THE SERVICES TO BE PROVIDED.

| | |
|---|---|
| _____ | _____ |
| Signature of EADC Director | Signature of Participant or Responsible Person |
| _____ | _____ |
| Date | Date |

# AGREEMENT FOR SERVICES

Edwards Adult Day Center (EADC) will provide the following Plan of Care for _____.

We will provide breakfast, lunch and an afternoon snack each day of attendance, provide the following interactive activities to include cognitive, physical, social and emotional programs to enhance quality of life and increase strength, and assist with normal activities of daily living. EADC will also provide care that matches the criteria stated in the Virginia Department of Social Services Regulations Manual, Department of Medical Assistance Service (DMAS) and the Veteran's Administration (VA). Depending on the funding source or the Private Pay rate, billing for services will be invoiced at the end of each month, and if payment is required, must be paid by the 15th of the billing month.

EADC will not be able to change a catheter, physically assist with bowel movements, and is bound by the regulations stated in the Virginia Department of Social Services (VADSS) Standards. If at any time the care being received at home changes, the Plan of Care that is in place at EADC will not be altered.

If the participant brings their personal lift to EADC, it will be used only to assist the client to and from the lift to the toilet, or a recliner in the EADC facility. EADC is not liable for repairs which may be needed for the lift for any reason while in the EADC facility. The participant will be the only person to use this lift.

As is the policy for all participants, EADC will guarantee 2 baths per week at a payment rate of $25 per bath which will be billed at the end of each month.

The goal at EADC is for staff and participants to establish and maintain a level of respect for each other. We also promote an atmosphere of friendship, companionship and overall kindness towards each other. The intention is to provide a safe and secure environment for all who work and use the EADC services.

To attest you have read and understand this agreement, please sign below. The Agency signature will attest that Edwards Adult Day Care will abide by the regulations stipulated by the Virginia Department of Social Services (VDSS) and provide the care needed in a safe and loving environment for all staff and participants.

| | |
|---|---|
| _____ | _____ |
| Executive Director | Participant |
| _____ | _____ |
| Date | Date |

Edwards
Adult Day Center

**Admission Date:**
___/___/_____

## APPLICATION FOR ADMISSION

**Participant's Information:**
Full Name: _____ Preferred Name: _____
Address: _____
Date of Birth: _____ Age: _____ Social Security #: _____
Participant's Phone Number: _____
Email Address: _____

**Participant's Marital Status:**
___ Single ___ Divorced ___ Widowed ___ Married
If Married, Spouse's Name: _____

**Primary Caregiver: The primary caregiver will be the MAIN contact for the participant.**
Name: _____ Relationship: _____
Address: _____
Phone: _____
Email Address: _____

**A copy of the following documents must be provided prior to enrollment if they exist:**
Does the participant have:
ADVANCE DIRECTIVE ___ YES ___ NO
DNR (Do Not Resuscitate) ___ YES ___ NO
POWER OF ATTORNEY ___ YES ___ NO
If yes, name of POA: _____
Phone of POA: _____
Address of POA: _____

**List TWO family members, friends, or a designated person to be contacted in the case of illness or an emergency - Licensing standards require TWO:**
Name/relationship: _____/_____
Phone: _____
Address: _____
Email Address: _____
Name/relationship: _____/_____
Phone: _____
Address: _____
Email Address: _____

**Site Visit Restriction**
List anyone who should not be allowed to visit the participant while at Edwards Adult Day Center:
Name: _____

**Physician Information**
Primary Care Provider: _____ Phone #: _____
Office Address: _____

**Please provide a copy of ALL current insurance cards (Check all that apply):**
___ Medicare ___ Medicaid ___ Private Insurance
Pay Source:
___ Private ___ Veteran's Administration ___ Medicaid #: _____

**Other Care Providers**
List any other Health or Social Service Providers:
Name of provider: _____ Phone #: _____
Address: _____
Choice of Hospital: _____

**Medications and Medical Devices**
Does the participant require either of the following: ___ Wheelchair ___ Cane ___ Walker
Will medications be administered by the center? ___ YES ___ NO
Does the participant have a pacemaker, defibrillator or any other medical device which the staff should be aware of? ___ YES ___ NO
What type of device:
___ Pacemaker ___ Defibrillator ___ Other: _____

**Please list special considerations we should be made aware of**
Mental Health: _____
Substance Abuse: _____
Behavioral Concerns: _____

**Please list FOOD, DRUG, or ENVIORNMENTAL ALLERGIES:**
FOOD: _____
DRUG: _____
ENVIORNMENTAL (i.e. outdoor pollens, bee stings, animal dander, dust, hand antiseptic, etc.):
_____

**Attendance and Transportation**
Planned attendance: ___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday
Planned transportation to and from the center: ___ EADC Bus ___ Family ___ Other

**The Following Information Is Optional**

However, the more we know about a participant the more we can interact and develop programs to maintain and improve functioning.

**(Please circle all that apply):**

**Mobility:**
- Ambulatory
- Cane
- Walker
- Wheelchair

**Motor Skills:**
- Right-Handed
- Left-Handed
- Good Control
- Poor Control

**Hygiene:**
- Independent
- Needs Assistance

**Communication:**
- Speaks Clearly
- Slow Speech
- Speech aphasia (distorted)
- Non-Verbal

**Eyesight:**
- Adequate, no correction needed
- Glasses
- Eye disease

**Sleep Pattern:**
- Nap needed
- Nap not encouraged

**Eating:**
- Feeds self
- Needs assistance
- Eats well
- Eats poorly
- Dentures

**Mental State:**
- Alert and Oriented
- Alert but confused at times
- Hallucinations at times
- Depressed
- Withdrawn
- Wanderer
- Aggressive
- Socializes Readily

**Toileting:**
- Continent __ Bladder __ Bowel
- Incontinent __ Bladder __ Bowel

**Auditory:**
- Adequate
- Hard of Hearing
- Hearing Aids? __ Left __ Right

**By signing below, I acknowledge that I understand the above consent.**

_____

Printed name of person completing application

_____ _____

Signature of person completing application Date

Edwards
Adult Day Center

## PARTICIPANT'S RIGHTS AND RESPONSIBILITIES

All participants shall be guaranteed the following:

1. The right to be treated as an adult, with consideration, respect, and dignity, including privacy in treatment and care of personal needs.
2. The right to participate in a program of services and activities designed to interest and engage the participant and encourage independence, learning, growth, awareness, and joy in life.
3. The right to self-determination within the center setting, including the opportunity to:
   a. Participate in developing or changing one's plan of care.
   b. Decide whether to participate in any given activity.
   c. Be involved to the extent possible in program planning and operation.
   d. Refuse treatment and be informed of the consequences of such refusal; and
   e. End participation at the center at any time.
4. The right to a thorough initial assessment, development of an individualized participant plan of care, and a determination of the required care needs and necessary services.
5. The right to be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided.
6. The right to a safe, secure, and clean environment.
7. The right to receive nourishment and assistance with meals as necessary to maximize functional abilities and quality and enjoyment of life.
8. The right to confidentiality and the guarantee that no personal or medical information or photographs will be released to persons not authorized under law to receive it without the participant's written consent.
9. The right to voice or file grievances about care or treatment and to make recommendations for changes in the policies and services of the center, without coercion, discrimination, threats, or reprisal for having voiced or filed such grievances or recommendations.
10. The right to be fully informed, as documented by the participant's written acknowledgment, of all participant rights and responsibilities and of all rules and regulations regarding participant conduct and responsibilities.
11. The right to be free from harm or fear of harm, including physical or chemical restraint, isolation, excessive medication, and abuse or neglect.
12. The right to be fully informed, at the time of acceptance into the program, of services and activities available and related charges.
13. The right to communicate with others and be understood by them to the extent of the participant's capability.

14. The rights of participants shall be printed in at least 14-point type and posted conspicuously in a public place in the center.
15. The center shall make its policies and procedures available and accessible to participants, relatives, agencies, and to the public.
16. Each center shall post the name and telephone number of the appropriate regional licensing administrator of the department; the Adult Protective Services toll-free telephone number; the toll-free telephone number of the Virginia Long-Term Care Ombudsman Program and any local ombudsman program servicing the area; and the toll-free telephone number of the disability Law Center of Virginia.
17. The rights and responsibilities of participants shall be reviewed annually with each participant, or, if a participant is unable to fully understand and exercise his rights and responsibilities, the annual review shall include his family member or his legal representative. Evidence of this review shall include the

date of the review and the signature of the participant, family member, or legal representative and shall be included in the participant's file.
18. A participant shall be assumed capable of understanding and exercising these rights and responsibilities unless a physician determines otherwise, and documentation is contained in the participant's record.

**I HAVE READ AND UNDERSTAND THE PARTICIPANT'S RIGHTS AND RESPONSIBILITIES**

_____ _____

Signature of Participant or Representative Date

**Annual Review**

_____ _____

Signature of Participant or Representative Date

_____ _____

Signature of Participant or Representative Date

_____ _____

Signature of Participant or Representative Date

# Photo & Field Trip Consent Form

**Initial and sign below to acknowledge:**

**Consent to photographs**
EADC may use photographs of the participant in print media for bulletin boards, newspapers, slide presentations, brochures, booklets, or in other forms of public formats. Photographs of the participant may also be posted in online platforms to include the EADC website (edwardsadc.org).

**PRINT MEDIA**
___ **I GIVE** permission for the participant's photograph to be used in any media.
___ **I DO NOT** give permission for the participant's photograph to be used in any media.

___ The participant **IS TO NOT HAVE THEIR PHOTOGRAPH TAKEN** at any time.

**State Licensing Requirement**
___ I understand that even without consent, photos will be taken and used in the participant's chart and emergency card to meet the EADC state licensing standards.

_____ _____
Signature of Participant or Guardian Date

**Field Trip Consent**
**Initial and sign below to acknowledge**

___ I give permission to the EADC for the above-named participant to go on field trips during regular business hours. Staff-to-participant ratio and the participant's safety will always be EADC'S top priority during planned outings.

___ The above-named participant **IS TO NOT GO** on field trips at any time.

_____ _____
Signature of Participant or Guardian Date

Edwards
Adult Day Center

431 Commonwealth Blvd, Martinsville, VA 24112 Phone:(276) 666-9400 Fax:(276) 666-4598

# REPORT OF PHYSICAL EXAMINATION

**Patient Information**

Patient Name: _____ Patient Phone: _____

Patient Address: _____ Date of Birth: _____

City, State Zip: _____

**Date of most recent examination (within 30 days of admission):** _____

Most Recent Height: _____ Most Recent Weight: _____ Most Recent Blood Pressure: _____/_____

**Diagnoses and ICD Codes:**

_____

_____

**Significant Medical History:**

_____

_____

**Allergies and Reaction**

Medication: _____

Food: _____

Animal: _____

**Does the Patient have an Epi Pen?** ___ Yes ___ No

**Do Not Resuscitate (DNR) Order**

Does the patient have a Do Not Resuscitate (DNR) order in your office? ___ Yes ___ No

**If yes, we ask that you send a copy with this medical statement.**

**Mobility**

Patient is Ambulatory ___ Yes ___ No

Patient is Non-Ambulatory ___ Yes ___ No

Is the patient capable physically and mentally of exiting the building in an emergency without the assistance of another person, even if he/she may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command? ___ Yes ___ No

Are there restrictions or limitations on physical activities or program participation? ___ Yes ___ No

If yes, please specify: _____

**Please list ALL therapy, treatments, or procedures patient is undergoing or should receive:**

_____

_____

**Diet Specifications:**

Does the patient have any special diet restrictions or any food intolerances: ___ Yes ___ No

If yes, please specify: _____

A regular diet is served, no salt added, visible fat removed, exchanges made when possible, and no concentrated sweets served. Is this Acceptable? ___ Yes ___ No

**ACTIVE MEDICATION ORDERS**

Please review medication list with participant's family during office visit which allows EADC to have the most updated medication list on file.

* If providing a medication list, state "See Attached" or MD sign and date medication list provided.

| Date Rx | Medication | Strength | Dosage | Frequency | Route | Prescribing MD |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Is the patient capable of administering their own medication? ___ Yes ___ No

May administer medications per family/participant's time scheduled at EADC? ___ Yes ___ No

**Physician Information**

Physician Name: _____ Physician Phone: _____

Physician Address: _____ Physician Fax: _____

City, State Zip: _____

_____ _____

**Signature of Physician** **Date**

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
www.vdh.virginia.gov

# Virginia Department of Health TB Program
## TB Risk Assessment (TB512)

See *Instructions for the TB Risk Assessment* for additional information and guidance

Patient name (L,F,M):_____ DOB:_____ Race:_____ Sex:_____

Address:_____ Hispanic or Latino: ☐No ☐Yes SSN:_____

City, State, ZIP:_____ Home/Work#:_____

Cell#:_____ Language:_____ Pregnant: ☐No ☐Yes ☐N/A; If yes, LMP_____

Country of Birth:_____ Year arrived in U.S.:_____ Interpreter needed: ☐No ☐Yes Last live vaccine:_____

**I. Screen for TB Symptoms** (Check all that apply)

☐None (Skip to Section II)
☐Cough for >3 weeks
→Productive: ☐Yes ☐No
☐Hemoptysis
☐Fever, unexplained
☐Unexplained weight loss
☐Poor appetite
☐Night sweats
☐Fatigue
} Evaluate in context

**Pediatric Patients**
(< 6 years of age)
☐Wheezing
☐Failure to thrive
☐Decreased activity, playfulness and/or energy
☐Lymph node swelling
☐Personality changes

**II. Screen for TB Infection Risk** (Check all that apply)

Individuals with an increased risk for exposure to TB or for progression to active TB disease once infected should have a test for TB infection.

**A. Assess Risk for Exposure to TB**
**The Patient…**

☐is a current high risk contact of a person known or presumed to have TB disease
☐lived in or visited another country where TB is common for 3 months or more, regardless of length of time in the U.S.
☐is a resident or an employee of a high TB risk congregate setting
☐is medically underserved
☐has experienced homelessness within the past two years
☐is an infant, a child, or an adolescent exposed to an adult(s) in high risk categories
☐uses injection drugs
☐is a member of a group identified by the health department to be at an increased risk for TB infection
☐needs baseline/annual testing approved by the health department

**B. Assess Risk for Progression to TB Disease if Infected**
**The Patient…**

☐is HIV positive
☐has risk for HIV infection, but HIV status is unknown
☐was recently (within past 2 years) infected with *Mycobacterium tuberculosis*
☐has certain clinical conditions that place them at high risk:
_____
☐uses injection drugs
☐has a history of inadequately treated TB
☐is >10% below ideal body weight
☐is on immunosuppressive therapy – includes treatment with TNF-α antagonists (Remicaid, Humira, Enbrel, etc.), other biologic response modifiers or prednisone ≥1mo. ≥15mg/day

| Yes | No | BCG History \| Test for TB Infection \| TB Treatment |
|---|---|---|
| ☐ | ☐ | History of prior BCG. Year:_____ |
| ☐ | ☐ | Positive test for infection: ☐IGRA ☐TST ____mm Date: _____ |
| ☐ | ☐ | Treatment for: ☐LTBI ☐TB Completed? ☐Yes ☐No Location:_____ Dates:_____ Regimen:_____ |

**III. Finding(s)** (Check all that apply)

☐Previous treatment for LTBI and/or TB disease
☐No risk factors requiring a test for TB infection
☐Risk(s) for TB infection
☐Possible presumptive TB disease
☐Previous positive test for TB infection, no prior treatment

**IV. Action(s)** (Check all that apply)

☐Issue screening letter
☐Refer for CXR
☐Complete a test for TB infection
☐Issue sputum containers
☐Refer for medical evaluation
☐Other:_____

☐**1. IGRA: ☐QFT ☐T-SPOT or ☐TST** Lot #:_____
Date given/drawn:_____ Time:_____ Site:_____
Signature:_____ POS#:_____
**TST Reading/IGRA Results**
Date Read: _____ Time:_____
Signature:_____ POS#:_____
Induration:____mm ☐Positive ☐Negative (TST or IGRA)
☐Borderline ☐Indeterminate ☐Invalid (IGRA only)

☐**2. IGRA: ☐QFT ☐T-SPOT or ☐TST** Lot #:_____
Date given/drawn:_____ Time:_____ Site:_____
Signature:_____ POS#:_____
**TST Reading/IGRA Results**
Date Read: _____ Time:_____
Signature:_____ POS#:_____
Induration:____mm ☐Positive ☐Negative (TST or IGRA)
☐Borderline ☐Indeterminate ☐Invalid (IGRA only)

Screener's signature:_____
Screener's name (print):_____
Date:_____ Phone#:_____

I hereby authorize the doctors, nurses, or nurse practitioners of the Virginia Department of Health to administer the Tuberculin Skin Test (TST) or draw blood for an Interferon Gamma Release Assay (IGRA) test from me or my child named above.

I agree that the results of this test may be shared with other health care providers.
The Deemed Consent for blood borne diseases has been explained to me and I understand it.
I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.
I understand that:

- this information will be used by health care providers for care and for statistical purposes only.
- this information will be kept confidential.
- medical records must be kept at a minimum for 10 years after my last visit, 5 years after death; for minor children, 5 years after the age of 18, or 10 years after the last visit, whichever is greater.

X_____ Date: _____
Client or Parent/Guardian Signature

Edwards
Adult Day Center

**Medication Policy – Edwards Adult Day Center**

It is the policy of EADC to maintain a locked cabinet to store all prescription medication for participants. Medication will be maintained in accordance to the Adult Day Care and Day Health Standards for Certification as follows:

- All medication shall be in the original container with the prescription label or direction label attached and legible. Sample medications shall be in the original packaging and labeled with the name and strength of the medication.
- All medication shall be labeled with the following:
  A. Participants Name
  B. Name of the medication
  C. Strength and dosage amount
  D. Route of administration
  E. Frequency of administration
- The medication shall be kept in a locked compartment or area, not accessible to participants. The locked compartment or area shall be free from direct sunlight and high temperatures, free from dampness, and shall remain darkened when closed.
- The area in which the medication is prepared shall have sufficient light so that the labels can be read accurately, and the correct dosage can be clearly determined.
- Medication shall be refrigerated, if required. When medication is stored in a refrigerator used for food, the medications shall be stored together in a locked container in a clearly defined area. If a refrigerator is used for medication only, it is permissible to store dietary supplements and foods and liquids used for medication administration.
- Unless it is contrary to the day care center's policy, a participant may take his own medication provided that:
  A. A physician has deemed the participant capable of administering medication to himself.
  B. The physician has given written authorization for the participant to self-administer medication to himself.
  C. Medication is stored in a locked area or compartment and provided to the participant by staff upon request.
- Any changes made to the participant's medication can be made by the Caregiver or the participant's physician. It is important that **any** change in the participant's medication be reported to the center so that the proper updates can be established by the staff.
- Medications left at the center for more than 15 business days after a participant is no longer enrolled, will be given back to the family member or will be disposed of by placing them in the sharp's box or taking them to the pill disposal site in the Henry County Sheriff's Department. The disposal of all medications will be witnessed by the Office Manager or the Executive Director and documented in a medication disposal file and will be placed in the participant's file. The medication disposal document will indicate that medication type and the quantity of medications disposed of and signed by all staff members that witness this process.

By signing below, I acknowledge that I understand the above content.

_____ _____

Signature of person completing application Date

# Consent to Exchange Information

**Notice of Agreement**

I understand different agencies may provide different services or benefits to Edwards Adult Day Center (EADC) participants and each agency must have specific information in order to provide these services and benefits.

By signing this form, I provide consent for the below agencies to exchange information so they may effectively work together to provide or coordinate services or benefits to the EADC participant.

**The following confidential information about the participant may be exchanged:** (Please check all that apply)

- Assessment Information/Plan of Care
- Medical Records/Medical Diagnosis
- Mental Health Diagnosis / Psychological Records/ Psychiatric Records

**This information can also be exchanged with:** (Please check all that apply)

- Primary Care Physician
- veteran's Administration
- Nursing Facilities
- Piedmont Community Service
- Martinsville Health Department
- Department of Medical Assistance Service (DMAS)
- Department of Social Services (DSS)
- Southern Area Agency on Aging (SAAA)
- Scholarship Administrators
- Pittsylvania County Community Action Agency, Inc. (Meals-on-wheels)

**Release of information to other medical providers:**

List the name of other offices and/or facilities that may have the participant's personal information:

Other doctor(s): _____

Hospice organization: _____

Hospital facility: _____

Other agencies that are allowed to exchange the participant's personal information:

_____

**By signing below, I acknowledge that I understand the above content.**

_____

Printed name of person completing application

_____ _____

Signature of person completing application Date

Today's Date_____/_____/_____

SITE # 016 Updated _____/_____/_____

## Client Name & Demographic Information

* Name: _____
(Last) (First) (Middle Initial)

* Address: _____
(Street)

_____
(City) (State) (Zip)

* Phone: ( ) _____ County or City of Residence: _____

Client's Customer ID: _____

Birthdate: _____/_____/_____ Gender: ____Male ____Female
(Month) (Day) (Year)

**Race Status:**

- ____ White or Caucasian Only
- ____ Black / African American Only
- ____ American Indian or Alaskan Native Only
- ____ Asian Only
- ____ Native Hawaiian or Pacific Islander Only
- ____ Some Other Race Only
- ____ Two or More Races Combined
- ____ Race Unknown or Unreported

**Hispanic Origin:**

____Hispanic or Latino Origin **OR** _____**Not** Hispanic or Latino Origin **OR** _____Hispanic Ethnicity Unknown

## Physical Environment

_____No one else lives in my home

_____Yes, I live with someone

## Financial Resources

Number of members in immediate family: _____

Total monthly income of immediate family: $ _____

In Federal Poverty? Yes_____ No ____

Sliding Fee Scale Level? A____B____C____D____E____F____G____
(If applicable)

For Office Use Only Services Provided:

Transport: _____ Soc/Rec: _____ Vol: _____ CMS: ✓

Nutrition Edu: _____

Medical Issues: _____

Agency/Provider: PITTSYLVANIA COUNTY COMMUNITY ACTION, INC.

**NOTE: At a minimum, this form must be updated annually in order for a client to continue service.**
*** Legal Assistance and Elder Abuse Services do not require these fields: Name; Address (Street, City, State, Zip) or Phone Number.**

# Determine Your Nutritional Health

*The warning signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.*

Read the statements below. Circle the number in the yes column for those that apply to you or someone you know. For each yes answer, score the number in the box. Total your nutritional score.

| | YES |
|---|---|
| I have an illness or condition that made me change the kind and /or amount of food I eat. | 2 |
| I eat fewer than two meals per day. | 3 |
| I eat few fruits or vegetables, or milk products. | 2 |
| I have three or more drinks of beer, liquor or wine almost every day. | 2 |
| I have tooth or mouth problems that make it hard for me to eat. | 2 |
| I don't always have enough money to buy the food I need. | 4 |
| I eat alone most of the time. | 1 |
| I take three or more different prescribed or over-the-counter drugs a day. | 1 |
| Without wanting to, I have lost or gained 10 pounds in the last six months. | 2 |
| I am not always physically able to shop, cook and/or feed myself. | 2 |
| **TOTAL** | |

## Total your nutritional score. If it's --

0-2 **Good!** Recheck your nutritional score in 6 months.

3-5 **You are at moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more **You are at high nutritional risk.** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

**Remember that warning signs suggest risk, but do not represent diagnosis of any condition. Turn the page to learn more about the Warning Signs of poor nutritional health.**

**MAJORITY OF STATE**

FEDERAL POVERTY / OAS SLIDING FEE SCALE

EFFECTIVE MARCH 1, 2023

**Name:** _____ **Phone:** _____

| NUM. IN FAMILY | Federal Poverty | GROSS INCOME Level A No Charge | GROSS INCOME Level B 10% Charge | GROSS INCOME Level C 25% Charge | GROSS INCOME Level D 50% Charge | GROSS INCOME Level E 75% Charge | GROSS INCOME Level F 95% Charge | GROSS INCOME Level G 100% Charge |
|---|---|---|---|---|---|---|---|---|
| 1 | Annual | $0 - 14,580 | 14,581 - 16,038 | 16,039 - 19,435 | 19,436 - 24,290 | 24,291 - 29,160 | 29,161 - 36,450 | 36,451 and above |
| | Monthly | $0 - 1,215 | 1,216 - 1,337 | 1,338 - 1,620 | 1,621 - 2,024 | 2,025 - 2,430 | 2,431 - 3,038 | 3,039 and above |
| 2 | Annual | $0 - 19,720 | 19,721 - 21,692 | 21,693 - 26,287 | 26,288 - 32,854 | 32,855 - 39,440 | 39,441 - 49,300 | 49,301 and above |
| | Monthly | $0 - 1,643 | 1,644 - 1,808 | 1,809 - 2,191 | 2,192 - 2,738 | 2,739 - 3,287 | 3,288 - 4,108 | 4,109 and above |
| 3 | Annual | $0 - 24,860 | 24,861 - 27,346 | 27,347 - 33,138 | 33,139 - 41,417 | 41,418 - 49,720 | 49,721 - 62,150 | 62,151 and above |
| | Monthly | $0 - 2,072 | 2,073 - 2,279 | 2,280 - 2,762 | 2,763 - 3,451 | 3,452 - 4,143 | 4,144 - 5,179 | 5,180 and above |
| 4 | Annual | $0 - 30,000 | 30,001 - 33,000 | 33,001 - 39,990 | 39,991 - 49,980 | 49,981 - 60,000 | 60,001 - 75,000 | 75,001 and above |
| | Monthly | $0 - 2,500 | 2,501 - 2,750 | 2,751 - 3,333 | 3,334 - 4,165 | 4,166 - 5,000 | 5,001 - 6,250 | 6,251 and above |
| 5 | Annual | $0 - 35,140 | 35,141 - 38,654 | 38,655 - 46,842 | 46,843 - 58,543 | 58,544 - 70,280 | 70,281 - 87,850 | 87,851 and above |
| | Monthly | $0 - 2,928 | 2,929 - 3,221 | 3,222 - 3,903 | 3,904 - 4,879 | 4,880 - 5,857 | 5,858 - 7,321 | 7,322 and above |
| 6 | Annual | $0 - 40,280 | 40,281 - 44,308 | 44,309 - 53,693 | 53,694 - 67,106 | 67,107 - 80,560 | 80,561 - 100,700 | 100,701 and above |
| | Monthly | $0 - 3,357 | 3,358 - 3,692 | 3,693 - 4,474 | 4,475 - 5,592 | 5,593 - 6,713 | 6,714 - 8,392 | 8,393 and above |
| 7 | Annual | $0 - 45,420 | 45,421 - 49,962 | 49,963 - 60,545 | 60,546 - 75,670 | 75,671 - 90,840 | 90,841 - 113,550 | 113,551 and above |
| | Monthly | $0 - 3,785 | 3,786 - 4,164 | 4,165 - 5,045 | 5,046 - 6,306 | 6,307 - 7,570 | 7,571 - 9,463 | 9,464 and above |
| 8 | Annual | $0 - 50,560 | 50,561 - 55,616 | 55,617 - 67,396 | 67,397 - 84,233 | 84,234 - 101,120 | 101,121 - 126,400 | 126,401 and above |
| | Monthly | $0 - 4,213 | 4,214 - 4,635 | 4,636 - 5,616 | 5,617 - 7,019 | 7,020 - 8,427 | 8,428 - 10,533 | 10,534 and above |
| Each Added Person | Annual | $0 - 5,140 | 5,141 - 5,654 | 5,655 - 6,852 | 6,853 - 8,563 | 8,564 - 10,280 | 10,281 - 12,850 | 12,851 and above |
| | Monthly | $0 - 428 | 429 - 471 | 472 - 571 | 572 - 714 | 715 - 857 | 858 - 1,071 | 1,072 and above |

Based on the poverty guidelines published in the January 19, 2023 edition of the Federal Register.

Based on the Department of Health's "Regulations Governing Eligibility Standards And Charges For Medical Care Services To Individuals", 12VAC5-200.