MemoryLane
CARE SERVICES

Dear Caregiver,

Thank you for expressing an interest in the Adult Day Center. We enclosed several forms.

1. The healthcare provider form should be filled out completely by the physician or other healthcare provider. It should indicate a negative TB test that has been done within the past year. The healthcare provider's office may fax the completed form to us or you may mail or drop it off.

2. Or, if you prefer that we reach out to the physician or healthcare provider for you, please fill out the release of information form, sign it, and return. Be sure to indicate the phone and fax number we should call.

3. Please complete the cost share application, making sure to sign and date on the back of the form.

As soon as all the completed forms have been received, we will call you to set an intake appointment. The appointment is usually about one and a half hours to complete.

We look forward to meeting you. Feel free to contact us at 419-720-4940 with any questions or if we may provide any other support.

Sincerely,

Allison Kodeih
Assistant Activity Director
Day Center Supervisor

Cheryl Conley, MA, LSW
Social Services Director

INITIAL HEALTHCARE FORM

Adult Day Services Program
2500 North Reynolds Road
Toledo, Ohio 43615
P: 419-720-4940 F: 419-720-4941
www.memorylanecareservices.org

Patient Name:_____ **Date of birth:**_____

Physician/Healthcare Provider:	
Phone Number:	Fax Number:

Tuberculosis Screening (Negative test result must be within the last year).

Date of Negative TB Result with documentation: ____ Skin Test or ___ QuantiFERON Blood Test

Standing Orders:

- Tylenol 325 mg 1-2 q 4hr prn, po for pain or fever.
- Ibuprofen 200 mg 1-2 tablets q 4-6 hr. prn po for pain or fever.
- Aerosol treatment as requested by physician order.
- Baby Aspirin for severe chest pain
- Tums
- Pepto Bismol

Nurse at Center may administer standing orders above? ☐YES ☐NO

Nurse at Center may Administer Prescribed Medications or other orders at Center? ☐ YES ☐ NO

Other Orders (please specify):

☐ Therapeutic meals:
☐ Nursing services:
☐ Nutritional consultation:
☐ Physical Therapy:
☐ Occupational Therapy:
☐ Speech Therapy:
☐ Other:

****PLEASE INCLUDE DIAGONSES, THE LAST OFFICE NOTE AND H&P, CURRENT MEDICATION LIST, NEGATIVE TB RESULT, AND ALLERGIES (DRUG, FOOD, ENVIRONMENTAL, AND DIETARY)**

Healthcare Provider Signature: **Date:**

For Office Use Only: *Above received and reviewed by MemoryLane Care Services Staff Nurse*

Staff Nurse Signature: Date:

MemoryLane
CARE SERVICES

ADULT DAY CENTER
PARTICIPANT COST SHARE ASSISTANCE APPLICATION

MemoryLane Care Services Adult Day Center is funded in part the Lucas County Senior Services Levy, State of Ohio Alzheimer's Respite Funds, Community State Block Funds and Older Americans Act Funds administered by the Area Office on Aging of Northwestern Ohio, and the Monroe County, Michigan Senior Levy Funds administered by the Monroe County, Michigan, Commission on Aging.

PROGRAM PARTICIPANT INFORMATION

Name: _____

Address: _____

City:_____State: _____Zip:_____

Phone Number: _____

Date of Birth: _____ Martial Status: _____Single _____Married

MONTHLY INCOME

Please indicate below the participant's monthly income from all sources including but not limited to income received from the following:

- Social Security
- Annuities
- Disability/sick benefits
- Interest
- Dividends
- Retirement benefits
- Public assistance
- Estate/trust fund payments
- IRA Income
- Farm income
- Veterans' benefits
- Pensions
- Rental property income
- Wages/Salary

Source of Income	Amount

TOTAL INDIVIDUAL MONTHLY INCOME _____

Insurance Provider: *_____

Group Number: _____

Policy Number: _____

Medicare Number: _____

Social Security #: _____

*** Please attach a copy of insurance card(s) or have them available at admission. Medicare Advantage plans may cover some Adult Day services***

To the best of my knowledge, the information provided above is true, accurate and complete disclosure of total income. I understand that these programs are supported, in part, by contributions from participants. If there is a significant change in any of the information provided, it will by my responsibility to notify MemoryLane Care Services.

_____ _____ _____

Signature of person providing information Relationship Date

Printed Name:_____ Phone Number:_____

For office use only

Monthly Income	Client

Client is eligible for cost share assistance: _____*Yes* **_____*No***

Full day rate*:*_____ Half day rate*:*_____

Cost Share Assistance Amount*:*_____

Transportation rate:_____

MEMORYLANE CARE SERVICES
AUTHORIZATION TO RELEASE INFORMATION/EXCHANGE CONFIDENTIAL INFORMATION

I, _____ authorize and agree for

Name of Healthcare Provider: _____

Address: _____

Telephone Number: _____

Fax Number: _____

☐ to release information

☐ to obtain information

☐ to exchange with

on _____
(printed name of individual attending adult day services)

to coordinate services for participation in the adult day center program, I request:

☐ Information to be disclosed: Current History and Physical and Medication List

_____

☐ Purpose of disclosure: To Coordinate and Provide Services at MemoryLane Care Adult Day Center

☐ Information will be disclosed to: MemoryLane Care Services

_____

I understand I have the right to refuse this form, and that I may revoke my consent at any time.

_____ _____
Signature Date

_____
Printed Name

☐ This information will not be used for any other reason than the purpose stated above

☐ This authorization and release expire on _____

Staff member requesting release: _____
Staff Printed Name/Signature Date