LIFESCAPE

Hello,

Welcome! The Lifescape Adult Day Program staff are excited to learn of your decision to join our community. It is our goal to enhance the quality of life for both you and your loved one.

Please take some time to complete all of the paperwork located in this intake packet. The information will assist us in developing the best possible plan of care for your loved one. If you should need some assistance in completing this packet, please do not hesitate to call or stop by our office, we are happy to help. We do expect that all medical requirements be completed just prior to start date in order to provide the center with the most current information. After our office has received the completed packet, we will gladly review it with you to determine the next steps in the admission process.

Once again, Welcome! We are honored to have you and your loved one join us here at Lifescape Adult Day Program. If you should have any questions, please do not hesitate to contact our office at 815-964-2433. You can speak to either Pat Harris, our Site Manager, or myself.

I look forward to working with you!

Sincerely,

Kelly Sanford

Kelly Sanford, CTRS
Lifescape Adult Day Program Director
1330 South Alpine Rd. Rockford IL, 61108
P:815-964-2433
F:815-987-1934
Email: ksanford@lifescapeservices.org

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FRIENDLY REMINDERS

PLEASE POST FOR EASY REFERENCE

Lifescape Adult Day Program
1330 South Alpine Rd, Rockford IL 61108
Phone #:815-964-2433
Fax #: 815-987-1934
Director: Kelly Sanford, CTRS
Site Manager: Pat Harris
Program Nurse: Lisa Hougan, LPN

When to Call:

- When your loved one will not be attend for any reason, if they are missing due to illness, please contact our program nurse.
- Change in days
- You are going to drop off or pick-up your loved one.
- They have a change of status, needs, contact info, or just to update their records.
- Please notify Pat when you wish for your loved one to attend on a different day. We ask that you call at least 24 hrs. prior.
- If you have any questions about your loved one, please contact Pat or Kelly for assistance.

Transportation Services:

- Please contact Pat to communicate any transportation changes. She will communicate those changes to the driver.
- We are a **CURB-To-CURB** service. Drivers **MUST** stay with the bus at **ALL** times.
- Someone must meet your loved one upon bus arrival.
- Driver will sound horn or call upon arrival. They cannot wait any longer than 5 minutes for a response. If there is no response the driver has been instructed to leave.
- If your loved one is unable to safely get into their home, the driver has been instructed to bring the client back to the center. You will be notified and someone MUST pick your loved one up prior to the center closing at 5pm.
- The path to the bus MUST be clear of obstacles. This includes snow, ice, & trash. Drivers are instructed not to attempt to pick up clients if a clear path is not available.

Reminders from the NURSE:

- If your loved one is coughing, has a runny nose, sore throat, vomiting, or diarrhea they MUST stay home until symptoms subside. If they are experiencing a fever, 100 degrees or more, they MUST be fever free for 24 hours with out the use of fever reducing medication before they can return. They may need to see a Doctor if symptoms persist.
- Any client that is out sick for 3 or more days must have a Doctors clearance prior to returning.
- If your loved one has been seen in an ER, Convenient Care Center, had a Hospital stay, or is out for an extended medical leave, a letter/note of clearance is required to return to programming. Any discharge information would be helpful to ensure continuity of care.
- If your loved one or anyone in close contact tests positive for COVID they must remain out for a minimum of 5 days, be symptom free, fever free for 24 hours, and retest & report results prior to their return. A home test is acceptable.
- All prescription and over the counter medications must have a doctors order on file in order for our program nurse to dispense. Medications must be current, and supplied in an appropriately labeled bottle. Clients are NOT allowed to carry medication around the center. Program nurse must be made aware of all medications entering the facility. If you have any questions regarding this, please contact our program nurse.
- Diabetics must bring own meters and supplies for use by the programing nurse. If you have extra supplies they can be left at the center.
- If your loved one has a change in medication, please provide our program nurse with a printed updated list from their provider so we may update our records.
- If you have any questions about your loved one's medication or any questions about their health, please contact our program nurse.

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Lifescape Adult Day Program
Face Sheet

Today's Date: _____

Client Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Phone: _____ **Payer Source:** ☐Private ☐CCP ☐VA ☐ORS ☐MCO ☐Other: _____

Medicare #	Medicaid #	Other Entitlement (Specify)

Living Arrangement:	☐Alone ☐Spouse ☐Partner ☐Adult Child ☐Other (specify):
Marital Status:	☐Married ☐Widowed ☐Single ☐Partner ☐Divorced or Separated
Race/Ethnicity:	☐White,not Hispanic origin ☐Black;not Hispanic origin ☐Hispanic ☐Asian; Pacific Islander ☐American Indian ☐Other (specify):
Language Spoken:	☐English ☐Spanish ☐Other(specify):
Religious Preference:	
Level of Education:	☐0-6th grade ☐7-12th grade ☐Diploma or GED ☐Some college ☐College graduate
Veteran Status:	☐No ☐Yes (if yes specify which branch)

Emergency Information

Primary Care Physician:	**Physician Phone #:**
Physician Address:	**Hospital Choice:** ☐SAH ☐RMH/Mercy Health ☐OSF ☐Other (specify):

Emergency Contact/Authorized Pick Up

(Please check box if person is authorized to pick up the client from Adult Day Program. Please sign reverse side for all individuals who are authorized to pick client up.)

☐1st Responsible Person:	Relationship to Client:	
Address:	Zip code:	
☐Home #:	☐Cell #:	☐Work # :
☐2nd Responsible Person:	Relationship to Client:	
Address:	Zip code:	
☐Home #:	☐Cell #:	☐Work # :
☐Responsible Person:	Relationship to Client	
Address:	Zip code:	
☐Home #:	☐Cell #:	☐Work # :

Lifescape Adult Day Program has trained personnel, including nurses, who strive to act in the best interest of clients. Occasionally, a client may become too ill to complete the day or may become too disruptive to remain in the center. If either occurs, the staff may need to call the family/caregiver to pick him/her up.
I agree to pick up ____if the staff determines it necessary.
I will make alternate arrangements for emergency pick-up on days I might not be easily reached.

I further agree to inform Adult Day Program staff of any situations or occurrences, which may affect the client's behavior while at the center.

____ ______________________

Signature of Client or Responsible Representative. Date

Additional Authorized Pick Up Emergency Contact Individuals (Optional)

☐Responsible Person:	**Relationship to Client:**	
Address:		**Zip code:**
☐Home #:	**☐Cell #:**	**☐Work # :**
☐Responsible Person:	**Relationship to Client:**	
Address:		**Zip code:**
☐Home #:	**☐Cell #:**	**☐Work # :**
☐Responsible Person:	**Relationship to Client:**	
Address:		**Zip code:**
☐Home #:	**☐Cell #:**	**☐Work # :**
☐Responsible Person:	**Relationship to Client:**	
Address:		**Zip code:**
☐Home #:	**☐Cell #:**	**☐Work # :**

****All additions or subtractions to authorized pick-ups and emergency contacts must be submitted in writing.****

For Private Pay Clients Only

Billing Sent To: ☐Client ☐1st Responsible Person ☐2nd Responsible person ☐Other (specify):	**Relationship:**
Billing Address:	

For Adult Day Program Staff Use Only

Form received: ______	Service started: ______	Funding: ______	CCP: Y N
Days attending: ______	Transportation: ______	IEF: F R P	
Discharge Date: _____	Reviewed by: _______		

LIFESCAPE

Lifescape Adult Day Program
Authorization of Disclosure

Authorization of Disclosure is requested for the purpose of evaluation, treatment, and coordination of services between service providers, community providers, family members, Long Term Care Insurance agencies, funding agencies, other identified parties and Lifescape Adult Day program.

Client Name: _____ **Date of Authorization:** _____

Individual(s)/Agency: _____

I authorize Lifescape Adult Day Program to exchange the following information with the identified individual or agency.

Reasons for Authorization of Disclosure:

☐Assure continuity of care
☐Address programming issues
☐Treatment recommendations
☐Address transportation issues
☐Address scheduling issues/attendance
☐Coordinate services between providers
☐Progress in treatment
☐Other (specify):_____

Information to be disclosed to Lifescape Adult Day Program:
General medical conditions/concerns; treatment recommendations; progress in treatment; transportation needs; funding needs; issues related to continuity of care; scheduling, coordination of services, and facility concerns.

Information to be disclosed from Lifescape Adult Day Program:
General medical conditions/concerns; treatment recommendations; progress in treatment; transportation needs; funding needs; issues related to continuity of care; scheduling, coordination of services, and facility concerns. This authorization of disclosure expires on _____ (up to one year from date of this authorization) OR until the authorization is revoked by client, responsible party/guardian. This authorization to disclose information may be cancelled at any time by written notification. This information will not be used for marketing purposes. A photocopy or fax of this authorization shall be considered as effective & valid as the original. If the client and/or responsible party/guardian refuse to consent to disclosure information, the consequences are: ☐NONE ☐Other: _____

I am aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

Client Signature: _____ **Date:** _____

Responsible Party: _____ **Date:** _____

A copy of this authorization to disclose information has been provided to the client/responsible party: ☐Yes

Lifescape ADS Staff: _____ **Date:** _____

Lifescape Adult Day Services staff maintains confidentiality of all participants as defined by Administrative Codes, including but not limited to Section 240.340; 240.1510 (a-1, 2; f-4o;)240.1555(d-11 and 2H);and, Health Insurance Portability and Accountability Act (HIPAA) or 1996. 45 CFR 164.508. Authority Sec. 1171-1179 of SSA (42 USC 1320-d 1329d-8), 262 of Pub L. 104-191,110 Stat 202-2031 and sec 264 of Pub. L 104-191 (42 USC 1320d-2 note)

LIFESCAPE

Lifescape Adult Day Program
Authorization of Disclosure: Medical Care

Authorization of Disclosure regarding medical care is requested for the purpose of evaluation, treatment, and coordination of services between medical doctor, providing clinic, hospital, adjunctive therapies, and Lifescape Adult Day Program.

Client Name: _____ **Date of Authorization:** _____

Doctor/Provider clinic/Individual(s): _____

I authorize Lifescape Adult Day Program to exchange the following information with my above listed medical provider.

Reasons for Authorization of Disclosure:

☐Assure continuity of care
☐Address programming issues
☐Treatment recommendations
☐Medication information
☐Address scheduling issues/attendance
☐Coordinate services between providers
☐Progress in treatment
☐Other (specify):_____

Reason for Authorization of Disclosure:

In order to exchange information about medical conditions; in order to provide appropriate medical care for me(client); in order to exchange information about my medications; in order to get results of medical testing; in order to assure continuity of care.

Information to be disclosed from the Doctors office to Lifescape Adult Day Program:

General medical conditions and concerns; change in medical status or presenting symptoms; medical diagnoses; medical history; prescribed medications; refill information; treatment recommendations; progress in treatment; lab results; and/or; other medication information as indicated.

Information to be disclosed from Lifescape Adult Day Program to the Doctors office:

General medical conditions and concerns; change in medical status or presenting symptoms; request for medication refills; questions and/or requests re: prescribed medications; treatment recommendations; progress in treatment; and/or other information as needed.

This authorization of disclosure expires on _____ (up to one year from date of this authorization) OR until the authorization is revoked by client, responsible party/guardian. This authorization to disclose information may be cancelled at any time by written notification. This information will not be used for marketing purposes. A photocopy or fax of this authorization shall be considered as effective & valid as the original. If the client and/or responsible party/guardian refuse to consent to disclosure information, the consequences are: ☐NONE ☐Other: _____

I am aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

Client Signature: _____ **Date:** _____

Responsible Party: _____ **Date:** _____

A copy of this authorization to disclose information has been provided to the client/responsible party: ☐Yes

Lifescape ADS Staff: _____ **Date:** _____

Lifescape Adult Day Services staff maintains confidentiality of all participants as defined by Administrative Codes, including but not limited to Section 240.340; 240.1510 (a-1, 2; f-4o;)240.1555(d-11 and 2H);and, Health Insurance Portability and Accountability Act (HIPAA) or 1996. 45 CFR 164.508. Authority Sec. 1171-1179 of SSA (42 USC 1320-d 1329d-8), 262 of Pub L. 104-191,110 Stat 202-2031 and sec 264 of Pub. L 104-191 (42 USC 1320d-2 note)

CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

(6/2017)

Adult Day Service Center _____

ENROLLEE'S NAME: _____
Last First Middle Initial

Date of Birth:_____ Age: _____

ENROLLEE'S ADDRESS: _____

_____
City State Zip

(____)_____
Telephone Number

Client/or Client Representative Signature: _____

Client's Social Security Number – last four digits only: X X X - X X - ____ ____ ____ ____

or mark the box below which indicates the client does not have a Social Security Number.

☐ Client does not have a Social Security Number

Privacy Act Statement: *The Department on Aging requires all information on this enrollment form to be completed. You must include the last four digits of the Social Security Number* ***of the client enrolled*** *in the Adult Day Service. This information is kept confidential, is used solely for identification purposes, data collection, and program enforcement.*

---

*Optional Information
Mark **One** Ethnic Identity: ___ Hispanic or Latino ___ Non-Hispanic or Latino

Mark **One or More** Racial Identities: ___Asian ___White ___Black or African American
___ American Indian or Alaska Native
___ Native Hawaiian or Other Pacific Islander

**This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect any aspect of your adult day service, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring this program is administered in a nondiscriminatory manner. Please be advised if you choose not to complete the above information, a visual identification of your race and ethnicity will be made and recorded in the data system.*

For center use only:
Enrollment Date:_____ Projected attendance days: _____ Projected hours:_____

CCP Client _____ or Other (Please specify payee source)_____ Projected meals _____

Functional Impairment
If Not Age 60: _____
Verification of Functional Impairment is required to be maintained in the client file and available for review.

Center Representative Signature:_____ Date:_____

Annual Update: _____ Annual Update: _____ Annual Update:_____

INSTRUCTIONS FOR COMPLETING THE CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Follow these instructions, if your household gets SNAP, FDPIR, SSI or Medicaid:

Part 1: List only the adult participants' names and ages.
Part 2: List the case number for any household member receiving [State SNAP] or [SSI] or [Medicaid] benefits.
Part 3: Skip this part.
Part 4: Answer this question if you choose to.
Part 5: Sign the form. If a case ID number for one of the above programs is provided the last four digits of a Social Security Number are not required.

ALL OTHER HOUSEHOLDS, follow these instructions:

Part 1: List only the adult participants' names and ages. For any participant with no income ($0), you must provide a brief explanation how housing, food, utilities, etc. are covered.
Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from this month or last month.
Column A–Name: List only the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you) with income and **who rely on the participant for economic support**. Attach another sheet of paper if you need to.
Column B – Gross Income and How Often it was Received: for each **household member who is a spouse, or dependent of the participant**, list each type of income received for the month. You must tell us how often the money is received – weekly, every other week, twice a month or monthly.
In Box 1 - list the **gross income,** not the take-home pay. Gross income is the amount earned before taxes and other deductions. You should be able to find it on your stub or your boss can tell you.
In Box 2 - list the amount each person got from the month from welfare, child support, alimony.
In Box 3 - list retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits.
In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, regular contributions from people who do not live in your household, and any other income. **If no income ($0) is declared, please provide a brief explanation how housing, food, utilities, etc are covered and include this amount under other income.** For ONLY the self-employed, under *Earnings From* Work, report income after expenses. This is for your business, farm or rental property. Do not include income from SNAP, FDPIR, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance as income.
Part 4: Answer this question if you choose.
Part 5: An adult household member must sign the form and list the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.

Privacy Act Statement: This explains how we will use the information you give us.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Part 1. All Household Members

Names of Adult Day Service Participant(s) (First, Middle Initial, Last)	Age

Part 2. Benefits: If any member of your household receives **Supplemental Nutrition Assistance Program [SNAP]**, **Medicaid**, or **Supplemental Security Income [SSI]**, provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Check which program applies: ☐ **Medicaid;** ☐**SNAP ;** or ☐ **Supplemental Security Income [SSI]**

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** spouse and those dependent on the participant(s) for economic support)	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

If $Ø (Zero) income is declared, please provide a brief explanation how housing, food, utilities, etc. are covered:

Part 4. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form.

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement below.)

Last four digits of your Social Security Number: X X X - X X - ___ ___ ___ ___ or

❑ I do not have a Social Security Number

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: Free_____ Reduced_____ Paid_____ Recipient of Medicaid, SSI, or SNAP: _____

Temporary (If applying for Medicaid) :

Free_____ Follow-Up Time Period: _____(expires after 90 days)

Determining Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

LIFESCAPE

Acknowledgment of Receipt of
Client Handbook & Understanding of Client Rights

Lifescape Adult Day Program respects the rights of the client and caregiver involved in our programing. Staff ensure client rights are maintained and respected as listed below.
The Right....

- To a safe, secure, supportive, & clean environment.
- To be treated as an adult, with respect & dignity.
- To confidentiality & privacy, in treatment, care of personal needs, & release of information without written consent.
- To be fully informed of all client's rights, responsibilities, rules, & expectations.
- To participate in a program of activities that encourages independent, growth, and ways to develop interests & talents.
- To be involved to the extent possible in: program planning, choice to participate, communication with others, & ones individualized plan of care
- To voice grievances about care or treatment without discrimination or reprisal.
- To end participation in the adult day program at any time.

The Lifescape Adult Day Program Client & Family Handbook describes important information about the Adult Day Program. It is the responsibility of the client & family/caregiver to familiarize themselves with the items listed in this handbook. If you should have further questions about the items in this handbook or specific program concerns, please consult with the Site Manager or Director at the center.

By signing below, you have acknowledged that the ADP staff have reviewed these rights with you & you have also received a program handbook highlighting these rights & responsibilities.

Client's Name (Print): _____

Client/Responsible Party's Signature: _____ **Date:** _____

Lifescape ADP Staff: _____ **Date:** _____

Lifescape Community Services - Adult Day Program

NOTICE OF PRIVACY INFORMATION PRACTICES

Effective Date: August 1, 2010
Revision Date: March 3, 2011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Lifescape Adult Day Program at 815-964-2433.

WHO WILL FOLLOW THIS NOTICE:

This notice describes our Center's practices and that of:

- Any health care professional authorized to enter information into your medical record.
- Any member of a volunteer group we allow to help you while you are in the Center.
- All employees, staff and other Center personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Center, whether made by Center personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Center personnel who are involved in taking care of you at the Center. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Center also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Center who may be involved in your medical care after you leave the Center, such as family members, clergy or others we use to provide services that are part of your care.

- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at the Center may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may tell your health plan about the services you may receive at the Center to obtain prior approval or to determine whether your plan will cover the services.

- **For Health Care Operations**. We may use and disclose medical information about you for Center operations. These uses and disclosures are necessary to run the Center and make sure that all of our participants receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may combine medical information about many Center participants to decide what additional services the Center should offer and what services are not needed. We may disclose information to doctors, nurses, technicians, medical students, and other Center personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Centers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific participants are.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Center.

- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities**. We may use medical information about you to contact you in an effort to raise money for the Center and its operations. If you do not want the Center to contact you for fundraising efforts, you must notify the Administrator in writing.

- **Center Newsletter**. We may include certain limited information about you in the Center Newsletter while you are a participant at the Center.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to an authorized party who is responsible for your medical care. We may also give information to an agency/authorized party who helps pay for your care. We may not tell your family or friends your condition and that you are in the Center unless authorized to do so. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all participants who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with participants' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for participants with specific medical needs, so long as the medical information they review does not leave the Center. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Center.

- **As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. If you are a member of the Armed Forces, we may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the Department of Veterans Affairs to determine if you are eligible for certain benefits. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the following:
    - To prevent or control disease, injury or disability;
    - To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - To notify the appropriate government authority if we believe a participant has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:
    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct at the Center; and
    - In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Administrator. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Center.

  To request an amendment, your request must be made in writing and submitted to the Administrator. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the Center;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Administrator. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a diagnosis you have.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing to the Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at the Center or by mail.

  To request confidential communications, you must make your request in writing to the Administrator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, request it in writing to the Administrator.

CHANGES TO THIS NOTICE

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the Center. The notice will contain on the first page, in the top right-hand corner, the effective date and any dates of revision. We will provide a copy of the revised notice upon request.

COMPLAINTS

- If you believe your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center, contact the Administrator at 815-964-2433. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION.

- Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Lifescape Adult Day Program
HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by asking the Administrator for one.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you or treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Client's Name: _____

Client/Responsible Party's
Signature: _____ **Date:** _____

Lifescape ADP Staff Name/Position: _____

Lifescape ADP Staff Signature: _____ **Date:** _____

LIFESCAPE

Lifescape Adult Day Program
Waivers

Hours of Service Calendar Signature Verification Form

The *Hours of Service Calendar* documents the dates and hours of each participant's attendance at Lifescape Adult Day Program. It is signed by the participant and a staff person on the last day of each month. If a participant is absent or otherwise unable to sign at that time, this form gives permission for the designated staff person to sign for him or her. In the event of the above named person's absence or inability to sign the *Hours of Service Calendar*, I hereby grant permission for Lifescape Adult Day Program staff person to sign in his or her place.

_____ _____

Signature of Client or Responsible Representative Date

_____ _____

Signature of Adult Day Program Staff Person Date

Waiver of Responsibility

I wave Lifescape Adult Day Program staff and assistants of all responsibility in case of accident, injury, illness, or loss of property.

_____ _____

Signature of Client or Responsible Representative Date

Alzheimer Association's Safe Return Program

"Safe Return" is a nationwide ID, support, & registration program. It provides assistance is a person becomes lost locally or far from home. Assistance is available 24/7, whenever a person is lost or found. There is a registration fee.

Information on the "Safe Return Program" can be found at www.alz.org/care/dementia-medic-alert-safe-return.asp.

☐ Is this client registered with the Alzheimer Association's Safe Return Program"? **Yes** Or **No**

LIFESCAPE

Visitors On Site

Lifescape Adult Day Program is dedicated to the promotion of independent living while creating a safe, structured and engaging environment for our clients. To help ensure the privacy, safety, and comfort of our program, we discourage visitation of family and friends during programming hours. However, in the event of an emergency whereas a visit is needed, please contact our office. All visits will be evaluated on an individual basis by the Management team.

By signing below, you are indicating that you have read and understand the above statement.

Client/Responsible Party's Signature: _____ Date: _____

Effective 10/1/2011
Updated: 1/12/2018

LIFESCAPE COMMUNITY SERVICES, INC.

Lifescape Community Services
Client Media Release Form

I, _____, hereby grant permission to Lifescape Community Services (LIFESCAPE) and its assignees, designees, and/or partners, the right to distribute, transmit, publish, copy or otherwise use, either in whole or in part, either digitally or in any other medium, my name, likeness, voice, and/or words, as well as the facts of my case (hereinafter "identifying information") in television, radio, films, newspapers, magazines, Internet, brochures, other media, and in any other form not herein described, for any of the following purposes:

- **Raising awareness about and promoting Lifescape Community Services programs;**
- **Educating the public about issues facing LIFESCAPE clients and persons similarly situated; and/or**
- **Informing persons or entities that provide or may provide funding or other support to LIFESCAPE about issues facing LIFESCAPE clients and persons similarly situated.**

I understand that LIFESCAPE will not sell my image or identifying information to any third parties for profit or other advantage.

I may cancel this authorization any time. I can do so by submitting a written request to the LIFESCAPE administrative office in Rockford. However, if reproductions of my identifying information have been included in any publications before I cancel, those publications may be distributed after I cancel.

LIFESCAPE shall not compensate me for use of my identifying information and use of such information does not benefit me in any way. Neither LIFESCAPE nor its assignees, designees, or partners shall be liable to me for use of my identifying information for purposes not specifically set forth in this agreement.

LIFESCAPE has informed me that I have the right to keep my case private and that I do not have to sign this release in order for the participant to receive services from LIFESCAPE.

_____ I **decline** to grant Lifescape permission to use my identifying information for education and promotion.

I hereby release and discharge Lifescape Community Services, and its assignees, designees, and/or partners from any and all claims, causes of action, and demands, now known or later discovered, for among other things, invasion of privacy, right of publicity, and defamation arising out of or in connection with the use of my identifying information.

I hereby warrant and represent that I am at least 21 years of age, have the full right to contract in my own name with respect to the matters stated above, and have no conflicting advertising or promotional commitments that would cause me to be unable to provide this release.

_____ **Accepted and Agreed**

Signature	Address
Print Name	Telephone
Date	Email

LIFESCAPE COMMUNITY SERVICES, INC.

Lifescape Community Services
Client Media Release Form (Legal Guardian)

I, _____, am the legal guardian of _____, an older adult/adult with disabilities (hereinafter "participant"). I hereby grant permission to Lifescape Community Services (LIFESCAPE) and its assignees, designees, and/or partners, the right to distribute, transmit, publish, copy or otherwise use, either in whole or in part, either digitally or in any other medium, the participant's name, likeness, voice, and/or words, as well as the facts of the participant's case (hereinafter "participant's identifying information") in television, radio, films, newspapers, magazines, Internet, brochures, other media, and in any other form not herein described, for any of the following purposes:

- **Raising awareness about and promoting Lifescape Community Services programs;**
- **Educating the public about issues facing LIFESCAPE clients and persons similarly situated; and/or**
- **Informing persons or entities that provide or may provide funding or other support to LIFESCAPE about issues facing LIFESCAPE clients and persons similarly situated.**

I understand that LIFESCAPE will not sell the participant's image or identifying information to any third parties for profit or other advantage.

I may cancel this authorization any time. I can do so by submitting a written request to the LIFESCAPE administrative office in Rockford. However, if reproductions of participant's identifying information have been included in any publications before I cancel, those publications may be distributed after I cancel.

LIFESCAPE shall not compensate me or the participant for use of the participant's identifying information, and use of such information does not benefit me in any way. Neither LIFESCAPE nor its assignees, designees, or partners shall be liable to me or to the minor participant for use of participant's identifying information for purposes not specifically set forth in this agreement.

LIFESCAPE has informed me that I have the right to keep the participant's identifying information private and that I do not have to sign this release in order for the participant to receive services from LIFESCAPE.

_____ I **decline** to grant Lifescape permission to use participant's identifying information for education and promotion.

I hereby release and discharge Lifescape Community Services, and its assignees, designees, and/or partners from any and all claims, causes of action, and demands, now known or later discovered, for among other things, invasion of privacy, right of publicity, and defamation arising out of or in connection with the use of participant's identifying information.

I hereby warrant and represent that I am at least 21 years of age, have the full right to contract in my own name with respect to the matters stated above, and have no conflicting advertising or promotional commitments that would cause me to be unable to provide this release.

_____ **Accepted and Agreed**

Print Participant Name	Legal Guardian Organization (if applicable)
Signature of Legal Guardian	Legal Guardian Address
Print Name of Legal Guardian	Legal Guardian Telephone
Date	Legal Guardian Email

LIFESCAPE

Lifescape Adult Day Program
Transportation Request Form

Please complete this form and return to Lifescape Adult Day Program as part of the intake process OR upon request

.

Client's Name: _____

Address: _____

Phone # (Home): _____ **Cell # (Cell):** _____

Please call client: ☐When on the way ☐Upon arrival
Driver should call: ☐Client @ home # ☐Additional #: _____
(please indicate)

Days of Service: M T W TH F
(Circle all that apply)

Special needs of client: ☐Wheelchair ☐Walker ☐Oxygen ☐Other: _____
(check all that apply)

Is the client subject to: ☐Seizures ☐Wandering ☐Other: _____
(check all that apply)

Special instructions for pick up/drop off: _____

_____

Does the client/family have a dog? ☐Yes ☐No

****All pets/dogs must be secured when Lifescape Adult Day Program arrives to pick up client.****

I have read the information regarding Lifescape Adult Day Program Transportation and agree with the policies and procedures described. I understand that the pick-up and drop off times will fluctuate per route, that the client must be ready when the Adult Day Program bus arrives and when it returns at the end of the day. **I understand this is a curb-to-curb service** and that the Adult Day Program drivers cannot help the client to/from the bus. I have been alerted that family and or caregivers are responsible for ensuring the client's ability to get to/from living environment to bus. I understand that if there are obstacles or dangers, the Adult Day Program bus will not provide transportation services. Such dangers include but are not limited to ice, snow, physical & structural obstacles, dogs, threatening environment. I understand that Adult Day Program transportation may be discontinued for reasons including, but not limited to failure to be ready when bus arrives, failure to follow curb-to-curb policy, failure to have responsible party at home for drop-off. I agree to contact Lifescape Adult Day Program if the client will not be in attendance so bus service may be canceled at the time of the absence.

Client/Responsible Party's
Signature: _____ **Date:** _____
Relationship to Client: ☐Self ☐Family Caregiver ☐Guardian ☐Other: _____

Client Name: _____

Date: _____

LIFESCAPE

Lifescape Adult Day Program
Client Activity Survey

I prefer
❑Being social ❑Working Independently

I prefer
❑Large Groups(8-10 participants) ❑Small Groups(1-3 participants) ❑Working Independently

I enjoy being physically active?
❑Yes ❑No*
If no, why?

I currently enjoy:
❑Playing cards ❑Playing dominoes

❑Talking about the past/reminiscing groups

❑Complex crafts
(Woodworking, pottery, painting, exc.)
❑Listening to music/singing
❑Dancing

❑Collecting items, If so what kind of items?
_____

❑Activity sheets
(Word search, cross word puzzles, sudoku, etc.)
❑Simple crafts
(Adult coloring, water colors, paper cutting & gluing exc.)
❑Playing board games

❑Reading ❑Watching TV &/or Movies
❑Active games ❑Parties/Celebrations
(Ball toss, bean bag toss, parachute, ring toss, etc.)
❑Other: _____
_____

I enjoy spiritual/faith-based activities?
❑Yes Or ❑No

I would be interested in attending/going on community outings/trips?
❑Yes Or ❑No

I prefer getting out in the community during the:
❑Spring ❑Summer ❑Fall ❑Winter

I enjoy the following community based "outings"
❑Going out to eat ❑Going to the movies ❑Shopping ❑Going to church
❑Attending special events ❑Attending concerts ❑Spending time in nature
❑Attending seasonal events (pumpkin patch, apple orchard, parades, exc)
❑Other: _____
_____

The following things get in the way of my participation in things I enjoy:

❑Lack of time ❑Lack of energy ❑Lack of money ❑Transportation
❑Physical limitations ❑Lack of supplies ❑No one to participate with
❑Other: _____

_____

To be completed by ADP staff:

Client able to follow
❑1 step direction ❑2 step directions ❑3 step directions

Client uses the following assistive devices:
❑Cane ❑Walker (aluminum/rolling) ❑Wheelchair ❑No assistive devices used
❑Glasses ❑Hearing aids

Client has the following diagnoses:
❑Dementia ❑Cognitive impairment: _____ ❑Cardiac Hx.
❑Stroke Hx. ❑Diabetic ❑Parkinsons ❑Mental Health Hx.
❑Other: _____

_____

_____ _____
Staff Signature Date

_____ _____
Reviewed By Date

Getting to Know You!

What was your former profession?

Are you married? If yes, for how long?

Is your spouse still alive? What is their name?

Do you have children? If yes, how many? What (is) are their name(s)?

Do you have grandchildren? If yes, how many?

Do you have great grandchildren? If yes, how many?

Have you been in the Armed Services? If yes, which branch of service?

What is your favorite movie?

What are some of your favorite hobbies?

What do you like to do?

What is a typical day like for you?

LIFESCAPE

Lifescape Adult Day Program: Physician's Form

Must be completed and returned to ADP prior to attendance.

Client Name: _____ DOB: _____ Age: _____

Height	Weight	Blood Pressure	Pulse	Respiration	**ALLERGIES:**

Medical Information/Diagnosis (Check all that apply)

Dementia:	☐Alzheimer's ☐Vascular ☐Lewy Bodies ☐Pick's Disease ☐Wernicke-Korsakoff ☐Creutzfeldt-Jakob
Stage:	☐Mild/Early Stages ☐Mid-stage ☐Severe/Late Stage
Diabetes:	☐Type I ☐Type II ☐Insulin ☐Oral ☐Diet Controlled
Cardiac	☐Coronary Artery Disease ☐Arrhythmia ☐Heart Failure ☐Angina ☐Pacemaker ☐Hypertension
Pulmonary	☐Asthma ☐Chronic Bronchitis ☐COPD ☐Emphysema
Stroke	☐CVA _____ ☐TIA _____
Seizures	☐History of Seizures ☐History of Epilepsy
Incontinence	☐Bladder ☐Bowel
Other Medical	☐Arthritis ☐Osteoporosis ☐Parkinsons'
Sensory	☐Hearing Loss ☐Cataracts ☐Glaucoma☐ Macular Degeneration ☐Speech Issues
Psychiatric	☐Depression ☐Anxiety ☐Bipolar Disorder ☐Schizophrenia ☐Hx violent/aggressive behavior
Other Medical Information/Diagnosis (please list or attach list):	

Client Current Medication List

Medications	Dosage	Frequency
***Please attach list**		

***Is this client able to self-medicate while at Adult Day Program? ☐Yes ☐Yes with reminders ☐ No**

Medications to be given @ Adult Day Program by Nurses (attach additional sheet if needed)

Medication	Dose	Frequency	Route

Dietary Considerations

*Please check all that apply

☐ NAS (no added salt) ☐NCS (no concentrated sweets) ☐Mechanical Soft ☐Cut Food

Client Name: _____ **D.O.B** _____

Health Maintenance/Immunizations

***Please note: A TB test is required of all clients. Initial TB test must be within the last 30 days of admission.**
Patient must have yearly TB test

TB Test Date: _____ **TB Test Results:** _____

Influenza Vaccine Date: _____ (If applicable)

Patient received COVID-19 Vaccine: ☐**No** ☐**Yes**

COVID-19 Vaccine **1st** Dose Date: _____ COVID-19 Vaccine: **2nd** Dose Date: _____

Patient is free of communicable diseases or infections: ☐**Yes** ☐**No***
If no, please state disease or infection: _____

_____

Physician Information

Physician Name:	**Please Return this Completed Form to:** **Lifescape Adult Day Program** 1330 South Alpine Rd, Rockford 61108 815-987-1934 (Fax) 815-964-2433 (Phone)
Office Address:	
Office Phone #:	
Office Fax #:	

I certify that I have examined this patient within the last three months and have reviewed patient's health history. I find patient appropriate and able to participate in Lifescape Adult Day Program.

Physician Signature: X _____ Date: _____

Physician Name (Please print): _____

(For Adult Day Program Nurse Use)

Date physician's form received: _____ Received By: _____

Received Via: ☐In person (drop off) ☐Mail ☐Fax ☐Other: _____

Notes: _____

_____

_____

_____

_____

HIPAA PERMITS DISCLOSURE OF DNR/POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

IDPH DNR/POLST

State of Illinois
Illinois Department of Public Health

DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One *(optional)*

❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One *(optional)*

❑ Long-term medically administered nutrition, including feeding tubes.

❑ Trial period of medically administered nutrition, including feeding tubes.

❑ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period)

_____

_____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

E — Signature of Attending Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Attending Practitioner Name *(required)*	Phone ( ) _____ - _____
Attending Practitioner Signature *(required)*	Date *(required)*

Form Revision Date January 2015 (Prior form versions are also valid.)

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2015

****THIS SIDE FOR INFORMATIONAL PURPOSES ONLY****

Patient Last Name	Patient First Name	MI

The Illinois Department of Public Health (IDPH) Do Not Resuscitate (DNR)/Practitioner Orders for Life Sustaining Treatment (POLST) **is always voluntary**. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	**Date Prepared**

Completing the IDPH Do Not Resuscitate (DNR)/POLST Form

- **The completion of a DNR/POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A DNR/POLST should reflect current preferences of persons completing the DNR/POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a Do Not Resuscitate (DNR)/POLST Form

This DNR/POLST form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another,
- or there is a substantial change in the patient's health status,
- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR)/POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR/POLST form requires completion of a new DNR/POLST form.
- Draw line through sections A through E and write "VOID" across page if any DNR/POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://www.idph.state.il.us/public/books/advin.htm

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

LIFESCAPE

Lifescape Adult Day Program
Authorization of Disclosure: Podiatry Services

Authorization of Disclosure regarding Podiatry Care is requested for the purpose of evaluation, treatment, and coordination of services between podiatry and medical providers, and Lifescape Adult Day Program.

Client Name: _____ **Date of Authorization:** _____

☐Accepted ☐Decline

Doctor/Provider clinic/Individual(s): Podiatry Services_____

I authorize Lifescape Adult Day Program to exchange the following information with the above listed Podiatrist provider.

Reasons for Authorization of Disclosure:

☐Assure continuity of care
☐Coordinate services between providers
☐Treatment recommendations
☐Medical history
☐Medication information
☐Progress in treatment
☐Other: _____
_____

Reason for Authorization of Disclosure:

In order to exchange information about medical conditions; in order to provide appropriate podiatry care for me(client); in order to exchange information about my medical history & medications; in order to get results of medical testing; in order to assure continuity of care & coordinate services between providers.

Information to be disclosed from the providers office to Lifescape Adult Day Program:

General medical conditions and concerns; change in medical status or presenting symptoms; medical diagnoses; medical history; prescribed medications; refill information; treatment recommendations; progress in treatment; lab results; and/or; other medication information as indicated.

Information to be disclosed from Lifescape Adult Day Program to the providers office:

General medical conditions and concerns; change in medical status or presenting symptoms; request for medication refills; questions and/or requests re: prescribed medications; treatment recommendations; progress in treatment; and/or other information as needed.

This authorization of disclosure expires on _____ (up to one year from date of this authorization) OR until the authorization is revoked by client, responsible party/guardian. This authorization to disclose information may be cancelled at any time by written notification. This information will not be used for marketing purposes. A photocopy or fax of this authorization shall be considered as effective & valid as the original. If the client and/or responsible party/guardian refuse to consent to disclosure information, the consequences are: ☐NONE ☐Other: _____

I am aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

Client Signature: _____ **Date:** _____

Responsible Party: _____ **Date:** _____

Lifescape ADS Staff: _____ **Date:** _____

A copy of this authorization to disclose information has been provided to the client/responsible party: ☐Yes

Lifescape Adult Day Services staff maintains confidentiality of all participants as defined by Administrative Codes, including but not limited to Section 240.340; 240.1510 (a-1, 2; f-4o;)240.1555(d-11 and 2H);and, Health Insurance Portability and Accountability Act (HIPAA) or 1996. 45 CFR 164.508. Authority Sec. 1171-1179 of SSA (42 USC 1320-d 1329d-8), 262 of Pub L. 104-191,110 Stat 202-2031 and sec 264 of Pub. L 104-191 (42 USC 1320d-2 note)