OKFD

Caring for adults with special needs since 1960

8421 N Walker Ave, Oklahoma City OK 73114
(405) 842-6636 www.OKFD.com

M.A.R. Identification

Name:_____ Admit Date:_____

Diagnosis:_____

Allergies:_____

BOD:_____ Age_____ Race:_____

Physician:_____ Phone:_____

Hospital Preference:_____

Emergency Transport:_____

Caregiver:_____ Phone:_____

Place Photo of Participant Here

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Member Application

Date _____

Name _____

Address _____ City _____ State _____ ZIP _____

Date of Birth _____ Phone Number _____ Cell _____

Emergency Pickup Phone Number _____

Caregiver Information

Name(s) _____ Relationship _____

Address _____ City _____ State _____ ZIP _____

Phone Number _____ Cell # _____ Work # _____

Newsletter Preference ☐ Mail ☐ Email

Email Address _____

Medical Information

Emergency Contact #1 _____ Phone# _____

Emergency Contact #2 _____ Phone# _____

Doctor's Name _____ Phone# _____

Hospital Preference _____

Allergies _____

Medical Diagnosis _____

Medication	Dose	Time

Parent/Guardian Signature _____

THIS INFORMATION WILL BE KEPT ON FILE FOR ALL MEMBERS OF THE OKLAHOMA FOUNDATION FOR THE DISABLED. PLEASE INFORM US OF ANY CHANGES SO WE CAN KEEP OUR RECORDS UP TO DATE.

A United Way Partner Agency

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Intake Assessment

Date: _____

Participant _____ _____ _____
Last First Middle

SSN# _____ DOB _____ Martial Status _____ Sex Male/Female _____

Medical Diagnosis _____

Primary Doctor _____ Phone # _____

Address _____

Secondary Doctor _____ Phone # _____

Address _____

Allergies:

Medication: _____

Food: _____

Last seen by physician _____ Reason _____

Numbers of days spend in the hospital in the last year _____

Special Diet _____

Insurance _____

Current Medical Status and History

Weight _____ Height _____

Eyesight	☐ Good	☐ Fair	☐ Poor						
Glasses	☐ Yes	☐ No	☐ Need						
Hearing Aide L/R/B	☐ Yes	☐ No	☐ Need						
Teeth	☐ Own	☐ Edentulous	☐ Dentures U/L						
Ambulation	☐ Self	☐ Cane	☐ W/C	☐ Walker	☐ Stand-By Assist				
Transfer	☐ Self	☐ Assist x1	☐ Assist x2	☐ Non-Weight Bearing					

HEALTH CONDITIONS

CONDITIONS	PAST	PRESENT	COMMENT
Alcohol/Substance Abuse	☐	☐	
Alzheimer's or Other Dementia	☐	☐	
Anemia/Bleeding Disorder	☐	☐	
Arthritis/Rheumatism	☐	☐	
Bladder: Continent, Incontinent/Dribbles	☐	☐	
Bowel: Continent, Incontinent	☐	☐	
Cancer/Leukemia	☐	☐	
Cateracts	☐	☐	
Circulation Problems	☐	☐	
Diabetes	☐	☐	
Difficulty With Food, Chewing	☐	☐	
Emphysemia: COPD, Asthma, Bronchitis	☐	☐	
Epilepsy/Seizure Disorder	☐	☐	
Falls: Recent History Of	☐	☐	
Glaucoma	☐	☐	
Heart Trouble/CHF	☐	☐	
High/Low Blood Pressure	☐	☐	
Hostile: Withdrawn, Depression	☐	☐	
Intellectual Disability	☐	☐	
Liver Disease	☐	☐	
Parkinson's Disease	☐	☐	
Skin Disorders/Pressure Sores	☐	☐	
Leg Ulcers/Burns	☐	☐	
Stomach/Intestinal Disorders	☐	☐	
Diaarrhea/Constipation	☐	☐	
Stroke	☐	☐	
Thyroid/Glandular Problems	☐	☐	
Tuberculosis	☐	☐	
Urniary Tract Disorders	☐	☐	
Wanders	☐	☐	
Other Illnesses	☐	☐	
Other Disabilities	☐	☐	
Other Injuries	☐	☐	

Any family history of the above mentioned health conditions? _____

If yes, please specify which conditions and the relationship to participant _____

_____

_____

_____

Current Medication	Dosage Frequency	Prescribing Physician

List Surgeries	Place	Date

List other non-surgical hospitalization

Reason	Place	Date

Any of the following in effect?

Power of Attorney	☐ Yes	☐ No
Legal Guardianship	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
DNR	☐ Yes	☐ No

Income Sources ☐ Social Security ☐ Retirement ☐ SSI
☐ Private Income ☐ Advantage ☐ VA

Are you eligible for DHS assistance? _____

Medicare # _____ Medicaid# _____

Services Requested or Required

☐ Nursing/Medical Monitoring	☐ Social Services	☐ Nutrition
☐ Socialization	☐ Recreation	☐ Personal Care
☐ Transportation	☐ Family Counseling/Support	
☐ Activities of daily living	☐ Other	

_____ _____
Participant/Caregiver/Guardian Date

_____ _____
Intake Worker Date

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Skills, Needs, and Goals Assessment

Participants Name _____

Date _____

Staff Completing Assessment _____

Answer Key:

T=Total Assistance S=Some Assistance P=Prompting Only I=Independent

Hygiene Skills:

Hand Washing _____ Toileting _____ Dental Care _____ Hair care _____

Comments _____

_____

_____

Social Skills:

Involved in Activities _____ Appropriate Social Interactions _____ Manners _____

Aggressive Behaviors _____ Stranger/Danger Concepts _____

Comments _____

_____

_____

Life Skills:

House Keeping Skills _____ Meal Prep _____ Emergency Safety _____

What academic skills could this individual work on? _____

_____

List any regular scheduled groups or activities this individual participates in ie: scouts, dance class, bowling _____

_____

_____

List any other areas or skills that this individual might benefit from working on with our encouragement or assistance _____

_____

_____

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Photograph and Voice Consent

I authorize taking my picture by photograph,. movie, and/ or videotape, and/ or recording of my voice by the OKFD staff or person's authorized by the OKFD, while participating in the Adult Day Gare services program.

Furthermore, I consent to and authorize thy use and reproduction of anr and all photographs, movie, videotapes, including prints, negatives and positives, or recording of my voice which they have taken of me or arranged to have thlcen for publicity, education or informational purpoes, without compensation tci> me. All prints, negatives, positives, and sound recordings shall remain the sole property of Oklahoma Foundation for the Disabled, Inc.

I understand that my refusal of consent for photographs or voice release will in no way affect my eligibility for the services of the OKFD or the care I receive as a participant the OKFD.

_____ _____
Participant/ Caregiver/ Guardian Date

_____ _____
Intake Worker Date

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Medication Administration

It is understood that the Adult Day Services and its staff will not be responsible for any adverse effects related to the administration of medication.

I _____ authorize the Oklahoma · Foudation for the Disabled., Inc. to administer any/all medications, to be taken by _____ (client), while attending the OKFD, and agree to provide the necessary dosages of these medications.

1. Only a certified or licensed staff member will give any and /all medications, including over-the-counter and prescription, during attendance at OKFD.
2. **Medication brought to the OKFD must be in a pharmacy bottle with proper pharmacy label or in the original bottle with the clients name on the bottle if a non-prescription medication. Any PRN medication given by OKFD staff must be approved by a doctor and provided by the client it will be used for.**
3. OKFD must have doctor's orders for all medications.
4. Medicine bottle label must match the doctor's orders given to facility.
5. If client is discharged, the medicine must be taken home upon discharge.
6. If client stops coming to the OKFD, we will send one (1) letter home advising the family to pick up all medications. If medication is still on site one (1) week after letter has been mailed, it will be destroyed, per facility policy.
7. If client should pass .away during enrollment at the OKFD, all medications will be destroyed, per OKFD policy.

_____ _____
Client/ Caregiver/ Guardian Date

_____ _____
Intake Worker Date

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Arrival/ Departure Information

Participant _____

Phone number of residence where participant will be transported from _____

Scheduled day/s of participation:

- Monday ☐
- Tuesday ☐
- Wednesday ☐
- Thursday ☐
- Friday ☐

Regular bus arrival time for pick up _____

Regular bus arrival time for drop off _____

Program hours are from 9am to 3:00pm. The pick up and drop off times will depend on when the bus is in your area.

I authorize the Oklahoma Foundation for the Disabled, Inc. staff to transport _____ in a vehicle owned and maintained by the Oklahoma Foundation for the Disabled, Inc.

I authorize the following individuals to transport above participant due to illness, disruptive behavior, or non-arrival of caregiver (proof of identification may be required before participant will be released.)

1. Name _____
   Address _____
   _____
   Phone _____
   Relationship _____

2. Name _____
   Address _____
   _____
   Phone _____
   Relationship _____

_____ _____
Participant/Caregiver/Guardian Date

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Transportation Agreement

I authorize the staff of Oklahom Foundation for the Disabled, Inc. t transport _____ for services at the Oklahoma Foundation for the Disabled, Inc. located at 8421 N. Walker Ave. from their residence at _____ in a vehicle owned and maintained by the Oklahoma Foundation for the Disabled, Inc. I understand that if a bus must wait more than 5 minutes to meet me (the caregiver) for a drop off or pick up, I will responsible for transporting the participant to OKFD or home in the event this occur. Participants will be returned to the facility by the bus driver if no one is there within the 5 minute time frame at the at the drop off site.

Signature: _____ Date: _____

Intake Worker _____ Date: _____

Outing Permission

I _____ give Oklahoma Foundation for the Disabled, Inc. permission to transport _____ on outings whenever weather and conditions permit them to do so. These outings will include trips to the lake, park, civic and cultural centers and places of interest in and around the Oklahoma City metro area.

I understand that my signature authorizes blanket permission to be used in the Oklahoma City metro area. Any lengthy trips, will require my signature on a specific document giving my permission for the trip. This specific document will state the whereabouts of such an outing.

The Oklahoma Foundation for the Disabled, Inc. will see that all safety precautions and quality care will be provided to the best of their ability at all times.

Signature: _____ Date: _____

Intake Worker _____ Date: _____

General Release of Liability

I would like to attend The Oklahoma Foundation for the Disabled , Inc. adult day services and participate in the daily program.
My participation is voluntary and I release and agree to hold harmless The Oklahoma Foundation for the Disabled, Inc. Adult Day Care Services, its employees, volunteers, and agents from any and all liability and responsibility (unless proximately caused by the willful misconduct of any of the above mentioned) for relating to any illness, accident, or other event which may occur while I am a participant in the program.

Signature: _____ Date: _____

Intake Worker _____ Date: _____

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Confidentiality Guidelines

1. All participant records will be kept and treated with strict confidentiality
2. Participant charts will be kept stored in a locked file cabinet.
3. All OKFD staff will sign confidentiality agreements as an employment requirement.
4. Participant records will be available only to Oklahoma Foundation for Disabled, Inc., Adult Day Care staff or other authorized persons unless release form is completed.
5. The participant, or their representative, must sign authorization for release of information to and from the Oklahoma Foundation for the Disabled, Inc. before any information will be released or requested.
6. Participants are not discussed in the presence of other participants or any unauthorized persons.
7. No information. concerning individual clients will be displayed in areas accessible to the public without consent.
8. Forms or documents containing participant information will be maintained in the OKFD for at least (5) years following termination of enrollment by the participant and then disposed of appropriately as confidential information.

I have read and accept the Oklahoma Foundation for the Disabled, Inc. confidentiality guidelines.

Signature: _____ Date: _____

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I. NOTICE OF GRIEVANCE RIGHTS
II Oklahoma Foundation For The Disabled, INC

It is the policy of Oklahoma Foundation For The Disabled, INC, often referred to as OKFD Daycare, to accept grievances and complaints from individuals it serves and supports and to process them according to the guidelines of the Office of Client Advocacy of the State of Oklahoma as well as any guidelines established by the Developmental Disabilities Services Division 1?f the Department of Human Services of the State of Oklahoma. OKFD will maintain a system for resolution of grievances by clients that meets the requirements of the Office of Client Advocacy, as described in OAC 340:2-3-45. The purpose of this Policy and Procedure is to provide clients a fair, simple, effective, and timely system of problem resolution. These procedures will ensure that clients can obtain a thorough review, fair consideration, and correction of problems as appropriate. Through these procedures, OKFD will also ensure that persons filing grievances are free from any type of harassment, coercion, reprisal, restraint, or discrimination. The Grievance Form can also be used to express concerns and complaints if a client, staff, family members, friends, advocates, or interested persons feel that their concerns or complaints have not been adresed appropriately in timely manner.

The local grievance coordinator for this agency is: Leona Stepney
She can be reached at: 405-842-6636

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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Policy and Procedures

It is the policy of OKFD to admit clients who might benefit from our level of support in the areas of life skills, recreational skills and social skills. OKFD will not accept clients who have needs greater than we can serve.

Procedures:

1. An application for services must be filled out by the first day of admission to our program.
2. A current medical report and assessment by the physician, including the following information, must be submitted within the first 5 working days of enrollment in our program.
   a. Physicians name and address
   b. Date of last visit
   c. Current illness or health problems
   d. CUrrent medication, dosage, time
   e. Dietary restrictions if any
3. Each must have an Individualized plan of care written within10 business days of entry into our program. The POC must be reviewed every 6 months or sooner.
4 If after 10 days, OKFD staff feel this client is not suited for this program because of behavioral, mental or physical conditions that require a different level of care, the client will no longer be allowed to continue in this program.
5. OKFD uses the following criteria as admission guidelines.
   a. Client cannot be physically abusive to others, nor exhibit repeated uncontrollable verbal abuse, or be sexually inapprortiate.
   b. Race, color, religion, gender, national origin, or marital status shall/will NOT affect the OKFD decision to admit for services.

I have read the admission policy and procedure, and to my knowledge _____ currently meets the admission criteria of the OKFD Adult Day Care Program and will be able to participate in the program.

Signature _____ Date _____

OKFD Admissions Officer _____ Date _____

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Notice of Privacy Practices
(HIPAA)

You have the right to receive a notice of our privacy practices with respect to your medical and billing information. Your signature here indicates that you have received a copy of our Notice of Privacy Practices.

_____ _____

Participant or Legal Representative Date

_____ _____

OKFD Representative Date

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Participants Rights

Each participant of the Oklahoma Foundation for the Disabled, Inc. shall be assured of the following rights:

1. To be treated as an adult, with respect and dignity regardless of race, color or creed.
2. To participate in a program of services and activities which promote positive attitudes regarding ones usefulness and capabilities.
3. To participate in a program of services designed to encourage learning, growth and awareness of constructive ways to develop ones interests and talents.
4. To maintain ones independence to the extent that conditions and circumstances permit, and to be involved in a program of services designed to promote independence.
5. To be encouraged to attain self-determination within the adult day care setting, including the opportunity to participate in developing ones care plan for service; to decide whether or not to participate in any given activity.
6. To be cared for in an atmosphere of sincere interest and concern in which needed . .. . -- support and services are provided.
7. To have privacy and confidentiality. {HIPAA Guidelines)
8. To be free of mental and physical abuse.
9. To be free of restrain unless under a physician's order as indicated on the individual plan of care.
10. To have access to the telephone to make or receive local calls, unless necessary restrictions are indicated in the individual care plan.
11. To be free of interference, coercion, discrimination or reprisal.

I have read these rights {or have had them read to me) and UNDERSTAND each of them.

_____ _____

Participant or Legal Representative Date

_____ _____

OKFD Representative Date

_____ _____

Intake Worker Date

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Termination of Service

Termination of service for a client may occur if the client:

- Has an acute illness, whicl1 OKFD staff members are unable to properly cope with.
- Has a cqmmunicable disease.
- Requires constant supervision by a nurse or program staff.
- Is physically abusive.
- Exhibits repeated and uncontrolled verbal abuse.2
- Acts out in a sexually inappropriate fashion.
- Requires care and services, which the OKFD staff is unable to provide due to advanced medical, physical, or psychosocial problems.
- Has and outstanding bill for 30 days
- Is in non-compliance with requirements for admission and continual enrollment.
- Poses a danger to self or others
- Poses any problem considered being disruptive to program as determined by the Executive Director, Case Manager or Nurse.

A client's services may also be terminated if a family member/guardian/managing conservator or Case Manager exhibits:

- An abuse of services. (Example: late or non-payment, consistent lateness in picking up client at the facility, not ready for transportation services, etc.)
- Any problem considered being disruptive to program as determined by the Director or Program Nurse.

Discharge procedures:
Once admitted to the program and a discharge becomes necessary, ti1e family member/ caregiver/guardian/ managing conservator or Case Manager will be notified by the Executive Director or designee by letter/ telephone and a discl1arge plan will be formulate and discussed with the client's responsible party.

Race, color, religion, gender, national origin, marital status, and/or payor source shall not affect the OKFD decision to terminate services.

Statement of Understanding:
I have read the termination criteria of tl1e Adult Day Services program. I agree to give the Executive Director of the Oklahoma Foundation for the Disabled, Inc., or their designee, full discretion in terminating services if my charge or family member, in the opinion of OKFD's staff, meets with one or any of the criteria for termination at any time during his/her participation at the Foundation.

Family member/guardian/managing conservator/Case Manager's name:

_____

Client's name:

_____

Date:

_____

Case Manager's signature:

ADULT FAMILY-SIZE AND INCOME APPLICATION (FSIA)
FY 2021-2022

PART 1. ALL HOUSEHOLD MEMBERS		
a. Name(s) of Adult Participant(s)		
b. Names of All Household Members (First, Middle Initial, Last)	**Age of Adult Participant(s)**	**Check If *NO* Income**
		☐
		☐
		☐

PART 2. BENEFITS

If any member of your household receives ***SNAP, FDPIR, SSI,*** or ***Medicaid*** benefits, provide the name and case number for the ***ONE*** person who receives benefits. ***If no one receives these benefits, skip to PART 3.***

NAME: _____ CASE NUMBER: _____

PART 3. TOTAL HOUSEHOLD GROSS INCOME. You must tell us how much and how often.				
A. NAME (List only household members with income)	**B. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED**			
	Earnings From Work Before Deductions	**Welfare, Child Support, Alimony**	**Pensions, Retirement, Social Security, SSI, VA Benefits**	**All Other Income**
Example: Jane Smith	$ *200 /weekly*	$ *150 /twice a month*	$ *100 /monthly*	$ _____/_____
	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____
	$ _____/_____	$ _____/_____	$ _____/_____	$ _____/_____

PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN).

An adult household member must sign this form. ***If Part 3 is completed, the adult signing the form also must list the last four digits of his or her social security number or mark the*** **I do not have a social security number** ***box.***

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center or day care home will get federal funds based on the information that I give. I understand that CACFP officials may verify (check) 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:

Last four digits of social security number: *-**-_____ _____ _____ _____**	☐ I do not have a social security number

PART 5. PARTICIPANT'S ETHNIC AND RACIAL IDENTITIES (Optional)			
Choose one ethnicity:	*Choose one or more (regardless of ethnicity):*		
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaskan Native	☐ Black or African American
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander	

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Physical Examination & Orders

Participant Name: _____ DOB: _____

Height Ft ____ In ____ Weight lbs ____ BP _____ (Range: _____ to _____)

Allergies:

Medication: _____

_____

Food: _____

_____

Medical Diagnosis _____

_____

_____

_____

_____

_____

Physical Examination: _____

Teeth: Edentulous ☐ Own Teeth ☐ Upper Dentures ☐ Lower Dentures ☐

Vision Good ☐ Fair ☐ Poor ☐ Glasses ☐

Hearing Good ☐ Fair ☐ Poor ☐ Hearing Aides Right ☐ Left ☐

Lungs _____ Heart _____

GI _____ Constipation ☐ Diarrhea ☐ Incontinence ☐

Extremities _____ Edema _____ Skin Condition _____

Mental Status

Memory Loss ☐	Short Term ☐	Long Term ☐
Dementia ☐	Type ☐	Stage ☐
Depression ☐	Anxiety ☐	Other ☐

Physician's Printed Name _____

Physician's Signature Date _____

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Physical Examination & Orders

Current Medications	Dosage	Frequency

Please check any over the counter medications that may be given. to your patient at the discretion of licensed personnel:

- ☐ Maalox 1000mg. Tab or liquid q 4 hr prn indigestion
- ☐ Tylenol 325/500 mg.· I or 2 tabs q 4-6 hrs prn pain or elevated temp
- ☐ Imodium AD 1 caplet after each loose stool x2 prn
- ☐ OTC throat lozenges 1 for sore throat or cough prn every hour x3

Other: _____

Date of last Influenza injection: _____

If diabetic-FSBS prn: Yes ☐ No ☐ (Normal Range: _____)

Diet: (No added salt diet provided at the center)

- ☐ Limited concentrated Sweets
- ☐ Chewing Difficulties
- ☐ Chopped
- ☐ Vulnerable to WT loss
- ☐ Swallowing Difficulties

Liquids: ☐ Honey thick ☐ Mechanically Soft ☐ Nectar Thick ☐ Pureed ☐ Pudding Thick

Activity Level: Full ☐ Limited ☐ Explain _____

Assistive Devices Cane ☐ Walker ☐ Wheelchair ☐ Braces ☐

Fall Risk ☐

PT Evaluation/Treat ☐

ADVANCE DIRECTIVE _____ DNR _____

Physician's signature: _____ Date: _____

Print Name: _____

Address: _____

Telephone: _____ Fax: _____

This form must be completed by a physician and should include the official diagnosis that qualifies them as having a disability.