



# BROWARD ADULT DAY CARE CENTER

## PICTURE AUTHORIZATION

NAME OF PARTICIPANT: \_\_\_\_\_

I \_\_\_\_\_ authorized the administration of **Broward Adult Day Care Center** to take a picture of me to be maintained in my record file for emergency purposes. Such a picture may only be used in the future in case of any emergency.

\_\_\_\_\_  
**Participant/Legal Guardian/Responsible Party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**OWNER/Administrator**

\_\_\_\_\_  
**Date**



# BROWARD ADULT DAY CARE CENTER

## DEMOGRAPHIC

No: \_\_\_\_\_ DATE OF ADMISSION: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apart. #. \_\_\_\_\_ City: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

D.O.B \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ F \_\_\_ Ethnic Group: \_\_\_\_\_

Social Security \_\_\_\_\_ Marital Status: \_\_\_\_\_ Clients Primary Language: \_\_\_\_\_

\_\_\_ Medicare \_\_\_\_\_

Medicaid \_\_\_\_\_ other \_\_\_\_\_

Caregiver:: \_\_\_\_\_ Relationship: \_\_\_\_\_ Occupation: \_\_\_\_\_

WorkPhone:: \_\_\_\_\_ Cellular: \_\_\_\_\_

Alternate: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact 1 \_\_\_\_\_

Phone number: \_\_\_\_\_

Emergency Contact 2 \_\_\_\_\_ Phone number: \_\_\_\_\_

Primary Doctor : \_\_\_\_\_

Psychiatrist /Neurologist: \_\_\_\_\_

Address \_\_\_\_\_ Phone : \_\_\_\_\_

Address \_\_\_\_\_ Fl \_\_\_\_\_ Phone : \_\_\_\_\_

Diagnosis; \_\_\_\_\_ PRECAUTIONS . \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

## FUNCTIONAL LIMITATIONS:

Medications: \_\_\_\_\_ STARTING DATE: \_\_\_\_\_

SCHEDULE: \_\_\_\_\_ Funding Source: \_\_\_\_\_ Funding Source Case

Manager: \_\_\_\_\_ Provider: \_\_\_\_\_ Transportation \_\_\_ STS \_\_\_ Family \_\_\_\_\_

Medicaid \_\_\_\_\_



## ADMISSION AND FINANCIAL AGREEMENT

This agreement is made this \_\_\_\_\_ day of \_\_\_\_\_, 2022  
between Broward Adult Day Care Center and

\_\_\_\_\_

### GENERAL CONDITIONS

**PERSONAL PROPERTY** It is understood that the center is not responsible for client's valuables, monies or clothing unless they are held in trust by the facility for safekeeping. Property shall not be considered held in trust unless a written receipt has been given to the client.

**TERMS AND CONDITIONS** The client or other party signing this agreement, if any, agree to abide by all of the terms and conditions set forth in this agreement.

**ACKNOWLEDGMENT** The client or other party signing this agreement hereby acknowledge (s) the following:

1. That each has received a duplicate copy of this agreement and any attachment there to.
2. That each has been given and oral explanation of the services provided by the facility and charges including those services offered on an as needed basis:

The client shall be dropped off at \_\_\_\_\_ am. and picked up at \_\_\_\_\_

### DAY OF ATTENDANCE:

\_\_\_ MONDAY                      \_\_\_ TUESDAY  
\_\_\_ WEDNESDAY                \_\_\_ THUESDAY  
\_\_\_ FRIDAY

Average Hours Attendance: \_\_\_\_\_

CENTER OPERATIONS HOURS 8.00 AM - 4.00 PM ;"(In case of any circumstance(s) causing delay the administrator of the facility must be contacted immediately and notified of the duration of the delay).

THE CENTER AGREES TO(IFNEEDED):

1. \_\_\_\_\_ Medication Supervision  
\_\_\_\_\_ Transportation \_\_\_\_\_ one meal  
per day and snacks

2. SERVICES:

- A) ART AND CRAFT
- B) MUSICAL ENTERTEIMENT AND SIGN ALONG
- C) MENTAL STIMULATION GAMES SUCH AS BINGO OR DOMINO.
- D) STRETCHING OR OTHER GENTLE EXERCISE AND MORE.

THE CLIENT AND/ OR RESPONSIBLE PARTY, IF ANY,AGREES TO:

1. Pay a rate of \$\_\_\_\_\_per day. This money shall be paid in full on the of each month. Any refunds will be prorated on a daily basis. Payable within 45 days are no exceptions.

\_\_\_\_\_

**Administrator's Signature**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Client's or Responsible Party**

\_\_\_\_\_

**Date**



BROWARD ADULT DAY CARE CENTER

2615 DAVIE BLVD. FORT  
LAUDERDALE FL. 33312

INFORM OF CONSENT OF MEDICATION

I, \_\_\_\_\_ hereby give permission for the Adult Day  
Care to assistance with medication to \_\_\_\_\_ As directed by  
physician. I understand that I will inform the administration if there are any  
changes by the attending physician.

\_\_\_\_\_  
**Participant's Signature /guardian's**

\_\_\_\_\_  
**Date**



**BROWARD ADULT DAYCARE CENTER**

**CONSENT AUTHORIZATION FOR RELEASE OF  
INFORMATION**

I, \_\_\_\_\_ authorize **BROWARD ADULT DAY CARE CENTER** release and obtain information to and from other agencies or persons as deemed necessary, in order to arrange services for me at BROWARD ADULT DAY CARE CENTER well as other Social Services Programs, in order that I may avail myself of all Programs which meet my needs, and for which I am qualified. There will be disclosure of this information unless there is a verified need, when required by a court order or for monitoring purposes. I understand that I will not be denied services for refusal to sign this form. However, refusal to sign this form or submit needed information may make it difficult to arrange assistance to help me.

**Signature:** \_\_\_\_\_

**Client**

**Signature:** \_\_\_\_\_

**Caregiver or Legal Guardian**

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_



## **BROWARD ADULT DAY CARE CENTER**

2615 DAVIE BLVD.FORT LAUDERDALE FL. 33312

### AUTHORIZATION FOR EMERGENCY TREATMENT

This gives Broward Adult Day Care Center authorization to give emergency medical treatment to \_\_\_\_\_ My hospital of preference is \_\_\_\_\_ The determination of the hospital to be used may be made by BROWARD ADULT DAY CARE CENTER

staff or by paramedics of the emergency medical services contacted. I understand that if a family member is with a communicable disease I will notify the center so they can inform other families as to whatever precautionary measures are necessary.

Date \_\_\_\_\_

Signature of responsive relative \_\_\_\_\_

Witness \_\_\_\_\_



## PARTICIPANT'S COMPLAINTS

### POLICY:

All participant's complaints will be filed and submitted to administrative Staff.

### PROCEDURE:

1. The participant pick/up a form in the office.
2. Within 24 hours of submission a verbal response to the complaint will be given.
3. If the response is not satisfactory, then a grievance

The meeting will take place with participants and administrative staff. Which will then lead to resolving the problem to their satisfaction.

4. The administrator needs to fill out the participant's complain long as soon resolve the situation.
5. Filing in the participant file

## Participant's Complaint Log

Date:-----

Time:-----

Name of participant giving complaint: \_

COMPLAINT \_\_\_\_\_

### GRIEVANCE :MEETING

Date: \_\_\_\_\_

Time: \_\_\_\_\_

\_\_\_\_\_  
Signature Of Administrative staff

\_\_\_\_\_  
Signature of Participants

Other person Attending meeting: \_\_\_\_\_

Explanation of how problem was resolved: \_\_\_\_\_



**BROWARD ADULT DAY CARE CENTER**

**Adult Day Care: Freedom from Communicable Diseases**

Date: \_\_\_\_\_

The purpose of this statement is to certify that \_\_\_\_\_  
is free from tuberculosis in the communicable form and documenting freedom  
from signs and symptoms of other communicable diseases.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



# BROWARD ADULT DAY CARE CENTER

## Adult Day Care: Acknowledgement of Comprehensive Emergency Management Plan (CEMP)

\_\_\_\_\_ have read or been explained the Comprehensive  
Emergency Management Plan for the Broward Adult Day Care Center. I have also been explained  
that the local Emergency Management Agency has a registry for disabled individuals who need  
assistance during evacuation or while in shelters due to physical or mental handicap(s).  
Broward Adult Day Care staff can assist participants with the registration with the Emergency  
Department Agency.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Participant/Guardian

Date

Print Name

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Witness

Date

Print Name



## **Adult Day Care: Acknowledgement of Evacuation Assistance Program**

I \_\_\_\_\_ have been informed, during the intake process, of the local emergency management agency's registry of disabled persons who need assistance during evacuations or when in shelters because of physical or mental handicaps and the assistance provided by the center staff to register such persons with the local emergency agency.

\_\_\_\_\_  
Participan/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



## TRANSPORTATION OF PARTICIPANT'S TO THE CENTER.

**POLICY:** The Day Care provided transportation from the home to the center.

### **PROCEDURES:**

1. All the participant's needs a transportation authorization from the responsible relative.
2. The center is responsible to pick-up the participants at morning time at home.
3. The relative is responsible to have some one in the house and the time of the drop-off.
4. If the participant's move to a new address the relative need to understand that the Center may not be able to provide the transportation.



## BROWARD ADULT DAY CARE CENTER

### TRANSPORTATION AUTHORIZATION

I hereby authorize BROWARD ADULT DAY CARE CENTER to transport to and /or from the Adult Day Care Center.

I understand that I must advise \_\_\_\_\_ if I am unable to attend his/her program by calling sufficiently ahead before the normal pick up time.

Should no responsible person be present at the time \_\_\_\_\_ is brought home, he/she (may) (may not) enter the house and remain unattended. If

· **The client cannot remain unattended . I am responsible for picking him/her up at the center. If I move to a new address, I understand that the Center may not be able to provide the transportation.**

\_\_\_\_\_  
Signature of Responsible

\_\_\_\_\_  
Relative Date



**BROWARD ADULT DAY CARE CENTER**

## **Adult Day Care: Acknowledgement of Policies and Procedures**

I \_\_\_\_\_ have read and/or been explained the Broward Adult Day Care: Policies and Procedure. I understand and agree to follow these policies and procedures at all times while in the center.

\_\_\_\_\_  
Participant/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness

PARTICIPANT'S BILL OF RIGHTS

1. Participants will respect the personal rights and private property of other participants.
2. Participants are allowed to retain services of his/her physician.
3. Participants will be free from mental and physical abuse and chemical and physical restraints.
4. Participants are assured the opportunity to exercise civil and religious liberties.
5. Participant will not be object of discrimination.
6. Participants will receive Policies and Procedures upon admissions.
7. Participant may be dismissed for medical reasons, or his programs or for non-payments.

I have received and agreed to the above Bill of Rights of Participants.

\_\_\_\_\_  
**Participant's Signature**

\_\_\_\_\_  
**Date**



## Acknowledgement of Participant Responsibilities and Right

I understand that it is my responsibility to comply with the center's policies and procedures and to respect the personal rights and private property of other participants and staff members.

**RIGHTS**• Participants are informed of services provided as evidenced by the Adult Day Care: Acknowledgement of Services Provided form provided at admission, the center's policies and procedures as evidenced by the Adult Day Care: Acknowledgement of Policies and Procedures, and of the responsibilities as a participant as evidenced by this form.

- Participants will be promptly informed of any significant changes to the policies and procedures, services, and rates.
- Participants will be informed during the registration to the center of the Adult Day Care: Comprehensive Emergency Management Plan and sign an acknowledgement form.
- Participants will be made aware of the emergency management agency registry for disabled individuals who need assistance during evacuations or when in shelters because of physical and/or mental handicaps and the assistance provided by the staff to register with the emergency management agency.
- Participants' may preserve the services of their primary care physicians and specialist physicians at their own expense or under coverage of a health care plan.
- Participants have the opportunity and are encouraged to participate in the planning of their care and schedule.
- Participants' are ensured an environment free from abuse, neglect, exploitation, chemical and physical restraints.

Drugs and other medications are not used for punishment, for the convenience of center employees, or in quantities that may interfere with participant's activities of daily living (ADL)

or rehabilitation.

Privacy is guaranteed for all personal and medical records. Adult Day Care employees treat participants with consideration, respect, and full recognition of their individuality, dignity, and right to privacy.

- Participants are not required to perform services for - Adult Day Care Center.

Participants are permitted to communicate and associate with the persons of their choice and to communicate with others to suggest or work for improvements in the center's participant's care.

- Participants may participate in the center activities of their choice.

Participants may take part in social, religious, and community groups/activities at their discretion.

- Participants are assured the opportunity to exercise religious and civil liberties, including the right to independent personal decision. No religious beliefs or practices, or attendance to religious services shall be imposed upon any participant. The center assists and encourages the exercise of these rights.

- Participants are not the object of discrimination with respect to participation in activities which include recreation, meals, leisure, and other social activities because of age, race, sex, religion, or nationality as defined in Title VI of the Civil Rights Act of 1964 or the Americans with Disabilities Act of 1990.

- Participants are not deprived of any constitutional, civil, or legal right solely for the reason of admission to the center.

- Participant is allowed to discharge him/herself from the center upon presentation of a request, preferably in writing; or if the participant has been adjudicated mentally incompetent, upon the written consent of his/her next of kin, sponsor, guardian, or responsible person. If at intake the participant was assessed as confused, he/she is not allowed to discharge his/herself until the Adult Day Care staff notifies the participant's guardian, spouse, or person having durable power of attorney.

- The participants are notified of their right to report abusive, neglectful, or exploitative practices. A sign is posted at a conspicuous location at the center at all times with the toll free telephone number they may contact.

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Participant/Guardian	Date	Print Name
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# BROWARD ADULT DAY CARE CENTER

On \_\_\_\_\_ I met with \_\_\_\_\_

\_\_\_\_\_ who explained the following procedures to me:

1. Programs and the Services by the Society.
2. The Services I will receive.
3. The process utilized in the development of goals set for me.
4. The person who will be my program manager and how my program will be managed.
5. The Financial arrangements including
  - a. rate for services I am to receive
  - b. the condition for payments
6. My rights and responsibilities.
7. The grievances and appeal procedures.
8. Emergency Management procedures

\_\_\_\_\_  
**Name of the person receiving the services**

\_\_\_\_\_  
**Signature**



BROWARD ADULT DAY CARE CENTER

PROGRESS NOTES

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



DATE: \_\_\_\_\_  
\_\_\_\_\_  
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