Advancing Abilities Day Program Admission Process:

- Please send copy of the IP
- Have a Team meeting to determine a goal for to be worked on during Day Habilitation. Or, if a team meeting is not needed proceed without as long as a goal is developed.
- Set Start Date – arrange transportation times

Services needed to be included in Plan:

- Adult Day Provided In-Person in a Setting Other than an Integrated Community Setting for a Group of Four or Fewer Individuals ADS code IO Waiver, FDS code Level 1 or SDS Self Empowered Waiver
- Adult Day Support Provided In-Person in an Integrated Community Setting for a Group of Four or Fewer Individuals IO waiver ADU, Self Empowered Waiver SDU, Level one waiver FDU
- 2 NMT per trip/day
- 50 miles per day for community integrated activity

Complete following items prior to beginning:

- IP updated to include Day program and signed by Advancing Abilities Day program Manager
- Advancing Abilities Emergency Consents
- Functional and ADL Needs form
- Bring all *paperwork listed on – Intake Checklist
- OTC/PRN Physician Order Form signed by physician
- Give - Bill of Rights
- Current Guardianship papers

Arrive on Day 1 of program:

- Nursing Assessment – completed Day 1 of start date

Advancing Abilities Intake Checklist

- Physical-within the last 12 months *
- Copy of medication list and allergies *
- TB test-within the last year
- Immunization Record that includes:
  a) Tetanus-within the last 10 years *
  b) MMR *
  c) Pneumonia
  d) Varicella *
  e) Hep B
  f) Flu
  g) Covid-19 and any boosters received.
- Copy of birth certificate *
- Copy of social security card *
- Copy of picture ID
- Copy of medical card/insurance card *
- Copy of Individual Plan *
- Copy of Self-Medication Assessment *

*=must have before admission

ANNUAL EMERGENCY INFORMATION/CONSENT FORM

Individual's Name:	Street Address:	City, State, Zip:	Phone #	
Date of Birth:	Social Security Number:	Medicaid Number:	Medicare / Insurance #	
Additional Agency: (if applicable)	Agency Contact Person: (if applicable)	Agency Phone/cell:		
Legal Guardian Name:	Legal Guardian Address:	**Phones**:	Work Phone:	
This Individual May Be Released **Only To The Following Authorized Person**(s) (if applicable):				
Physician Name:	Physician Address:	Dr. Phone:	Date of last exam:	
Dentist Name:	Dentist Address:	Dentist Phone:	Date of last exam:	
Medical Specialist Name:	Medical Specialist Address:	Dr. Phone:	Date of last exam:	
Emergency Name, Phone & Relationship of Person(s) Authorized/Responsible If You Cannot Be Reached: **(#1)** **(#2)**				
Please list any/all **medical diagnosis** (use attachment if necessary): **Physician's orders on file**		**Date last TB test:** **TB Results:** – +		
Known Allergies:		**Hospital Preference:**		
Date of **last known tetanus shot:**	Dates of **Hepatitis B** Immunizations: 1st dose: 2nd dose: 3rd dose:			

Take Medications at home? ☐ Yes ☐ No **Take medications at work?** ☐ Yes ☐ No

Does this person need treatments to be given at work? ☐ Yes ☐ No

If Yes to medications or treatments to be given at work, list medication and/or treatment and time to be given: _____

_____

When more information is needed, family or guardian will be contacted.

Type of **Diet**: ☐**Regular** ☐Other (please name & explain): **Restrictions:**

ADAPTIVE DEVICES USED BY THIS PERSON: ☐ **Dentures** ☐ **Eyeglasses** ☐ **Braces** ☐ **Splints** ☐ **Orthotics**

☐ List others:

AMBULATION: ☐ Independent, or ☐ Assist ☐Walker ☐ Cane ☐ Wheelchair (☐ manual or electric ☐ standard)

COMMUNICATION: ☐ Verbal ☐ Non-verbal ☐ Uses Signs Language ☐ Gestures

_____

Individual and guardian signature Date

PERMISSIONS

I have reviewed and I understand the conditions of this Emergency Information/Consent Form.
My initials as marked and my signature below indicate I agree to cooperate with the following conditions:

Initial Each Box	Please read carefully and initial each separate type of permission listed below.
	PERMISSION TO RELEASE MEDICAL INFORMATION: I hereby give my permission that health/medical/nursing information may be shared with ADVANCING ABILITIES staff, including nursing, transportation, ambulance staff, & emergency medical staff who may need to treat or work with this person. Also the residential provider, and an insurance company or other third party payer (Medicare) that processes claims, a party to litigation involving the client or the facility. ☐ **I give my permission** to release medical information ☐ No, I **DO NOT** give my permission.
	TREATING and TRANSPORTING in EMERGENCY SITUATIONS: In all cases, nurses and/or administration will use their professional judgment and 911 will be contacted first when it is determined immediate medical treatment is required. ADVANCING ABILITIES will provide first aid and will make efforts to contact the parent/ guardian/caregiver as soon as feasible. Payment of fees will be the responsibility of the parent/caregiver/guardian.
	PHOTOS: I understand that at times various media or promotional coverage of ADVANCING ABILITIES events will take place for publicity and/or public relations purposes. I further understand that I give permission for use of pictures for ADVANCING ABILITIES related to habilitation or ADVANCING ABILITIES promotional or advertising, and for identification. ☐ **I give my permission** for pictures and photos to be used ☐ No, I **DO NOT** give my permission.
	JOB CONFIDENTIALITY: I understand that I may be given the opportunity to work on contracted jobs while attending ADVANCING ABILITIES. The materials that I will be working with are the property of the company paying me to fulfill the job. I understand that I may not take, read, hoard, discuss or share any property that belongs to the company providing the materials for the job. Some materials may be of a confidential nature, and I may not divulge any information to my peers, family or other employees of ADVANCING ABILITIES.
	COMMUNITY OUTINGS: ADVANCING ABILITIES may travel around various sites in this community or adjacent communities. Separate permission slips will be sent out for trips outside the normal distance of community travel. ☐ **I give my permission** for participation in community outings. ☐ No, I **DO NOT** give permission..
	Receipt of bill of rights: I acknowledge that I have received a copy of the list of rights of persons with developmental disabilities, and these rights were communicated to me in a way I can understand.
	I have a **Do Not Resuscitate Order or an Advanced Directive** and that order or directive will be followed in time of crisis. Proper documentation has been obtained. *ADVANCING ABILITIES requires all documentation needed to follow a DNR*

	I hereby give my permission that trained and certified Medication Administrators and nursing may administer a medication that is on the Physicians' Order. Any medications and/or supplies administered will be supplied by the provider.

_____

Signature of Individual/Parent/ Guardian ***this signature and these permissions valid for one year from this date*** **Date**

I. Transportation Information

☐ **Consumer will bring medications to work**
- ☐ Driver to lock during transportation, then deliver to Nurse
- ☐ Person will carry their own meds

☐ **Known Seizure history?** No ___ Yes___ If yes: Frequent _____ Occasional/rare _____
☐ **Known history or diagnosis of Diabetes?** No ___ Yes ___
☐ **Uses Oxygen: observe color / shortness of breath.**
☐ **Cardiac (heart) condition:**
☐ **Respiratory (breathing) condition:**
☐ **Ostomy, bladder or other catheter in place.**
☐ **Feeding tube, IV, or other venous line in place.**
☐ **Equipment Transport** – Specify details:

Comments: _____
Special directions to home:
_____
Specific pick-up / drop-off instructions:
_____

_____

PD/Manaager Signature Date

Scioto Trails | Advancing Abilities
Quality Services · Quality Lives

Check √ all that apply

Functional Status:	√	Communication:	√
No functional Impairment		Easily Understood	
Impaired Vision		Difficult to understand	
Blind		Nonverbal but understands some	
Impaired Hearing		Signs with Standard Sign Language	
Deaf		Signs-Uses own gestures	
Other:		No Receptive or Expressive Language	

Check √ all that apply

Assistance with Daily Needs:	√	Adaptive Equipment:	√		√
Medication		Glasses		G/J Tube	
Eating		Cane		Wheelchair	
Dressing		Hearing Aid		Oxygen	
Toileting		Walker		Communication Device	
Bathing		Trach		Other:	
Dental Care		Prosthesis			

Signed (person completing above info):_____Date_____

Signed (employee receiving services):_____Date_____

For Nursing Use Only

Date Form Received: _____Nurse receiving: _____

OTC/PRN Expiration Date:

OTC/PRN Physician Order Form

Name: _____**DOB**: _____**Date**: _____

Address: _____**Guardian Name**: _____**Allergies**: _____

Name of Physician: _____**Address**: _____

Phone: _____**Emergency Phone**: _____**Fax**: _____

Routine Medications:

Medication/Dosage	Route/Frequency	Physician	Diagnosis

***May attach medication list and allergy list, if more room is needed**

Standing Orders for OTC/PRN's (check allergy list before giving any OTC):

Symptoms:	Medication/Dose:	Route/Frequency:
Headache/Fever = or >101	Acetaminophen 325mg 2 tablets	Every 4 hours as needed
Body Aches/Pain	Ibuprofen 200mg 2 tablets	Every 6 hours as needed
Allergic Reaction	Benadryl 25mg 1 tablet	Every 6 hours as needed
Sore Throat	OTC Cough Drops 1 Lozenge	Every 1 hour as needed
Cough	OTC Cough Drops 1 Lozenge	Every 1 hour as needed
Diarrhea	Loperamide 2 mg 1 tablets DO NOT EXCEED 4 DOSES IN 24 HOURS	Initial dose of 2 tablets after 3 loose stools then 1 tablet after each subsequent loose stool
Heartburn/Indigestion	Mylanta 30ml MAX OF 6 DOSES IN 24 HOURS	Every 4 hours as needed
Nausea/vomiting/Upset Stomach	Mylanta 30ml MAX OF 6 DOSES IN 24 HOURS	Every 4 hours as needed

OTC Products for Preventative Use:

Sunscreen SPF 30 or greater with UVA & UVB protection *	Sunscreen	Apply to exposed skin 30 minutes prior to exposure, reapply as needed

***Mark a line through OTC's not to be administered to individual; specify frequency or dosage if different than written.**

Other: _____

****A physician must sign this form**

Physician's Signature: _____**Date:** _____

(Order good for one year)

Medical Records Release Form

Client Name:

Address: _____ City:_____ State:_____ Zip:

Telephone Number:

Date of Birth: _____ Social Security Number: _____-___-

I authorize the release of my medical records or other health care information, including reports, diagnosis lists, medications, and other written information concerning my health and treatment during the period of _____ to _____; to be sent to the following person or company.

Company: Advancing Abilities

Address: 112 Oliver Street Piketon, OH 45661

Telephone : 740-443-6155 Fax: 740-443-6158

Client/Guardian Signature: _____ Date:

Witness Signature: _____ Date: