Brain Injury Services

Adult Day Program

Referral Packet

Return to lindsayp@htop.org
1405 Wellington Ave., Grand Junction, CO 81501
Fax (970) 242-6609

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Thank you for your interest in Hilltop's Brain Injury Services Adult Day Program!

Assessment Process:

Step 1: Referral packet review
Step 2: Interview and tour reviewing services and overall program
Step 3: Assessment with Adult Day Program leadership
Step 4: Admission to Adult Day Program

If the applicant is determined an appropriate fit for services offered, arrangements will be made to participate in the program for a minimum of 3 hrs. This is at no cost to the applicant. The referral packet must be fully complete, signed and returned to begin the assessment process.

Admission Criteria:

Only applicants who meet the below criteria will be admitted to the Adult Day Program:

- 21 years or older
- Service needs can be met
- Medically stable, not requiring 1:1 supervision
- Free of contagious diseases
- Will benefit from socialization and stimulation in a safe and supportive environment
- Adequate funding source to meet service cost

Known behaviors posing potential risk to self or others will be reviewed and determined on a case by case basis. Applicants that are determined able to be supported by the program and staff may be admitted.

The Adult Day Program specializes in serving individuals with brain injuries. Individuals without a brain injury may be considered for admission if able to be supported by the program and can socially interact with the individuals with specialized diagnoses.

Documents to Include:

Step 1: Submit the following to schedule interview:

_____ Complete Referral Packet

_____ Referral Application

_____ Release of Confidential Information

_____ Health Status Inquiry (signed by physician)

Step 2: Submit the following prior to assessment:

_____ Service Agreement

_____ Copy of valid social security card

_____ Copy of valid identification

_____ Current insurance cards

_____ Advanced Directives and MOST form (if applicable)

_____ Current physical and history

_____ Current medication list

_____ Guardianship, power of attorney, and/or durable medical power of attorney

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ADULT DAY PROGRAM
Referral Application

PARTICIPANT INFORMATION

Date: _____

Full legal name:			
Nickname:		Phone number:	
SSN:		DOB:	Age:
Birthplace:			
Height:	Weight:	Hair color:	Eye color:
Identifying characteristics (birthmarks, tattoos, etc.):			
Address:			
Who do you live with?			

Do you have a legal guardian or power of attorney? _____ Yes _____ No

Name	Type	Phone Number

SOCIAL HISTORY

Level of education:
Job status:
Marital status:
Spouse name & phone number:
Children names & ages:

ACTIVITY INTERESTS

Interests & hobbies:
Current activities:
Favorite music:
Exercises you like:
Educational Interests:
Social Interests:

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EMERGENCY CONTACT INFORMATION

Primary Emergency Contacts

Name	Relationship	Address	Phone Number

Other Family Member(s)

Name	Relationship	Address	Phone Number

INSURANCE INFORMATION

Medicaid #:
Caseworker name & phone:
Medicare #:

Other Insurance

Company Name:		
Address:		
Policy Number:	Group Number:	Contact Number:

DRUG & ALCOHOL HISTORY

Please describe any ***past*** use of alcohol or other drugs:
Please describe any ***current*** use of alcohol or other drugs:
Discuss any past or present treatment or sobriety services:

CRIMINAL HISTORY

	YES	**NO**	**If Yes, please explain**
Have you ever been convicted of a crime?			
Are you currently under court ordered supervision?			

Contact information for supervising party:		
Name:	Agency:	Phone:

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MEDICAL HISTORY

Current *Medical* Diagnoses

Type/Cause	Date of Onset	Current Treatment

Current providers

Name	Address	Phone Number

Current *Psychiatric/Psychological* Diagnoses

Type	Date of Onset	Current Treatment

Current providers

Name	Address	Phone Number

Allergies

Type/Cause	Known Reaction	Treatment

Medications (list all current medications, prescription and over the counter)

Drug	Dose/Frequency	Prescribing Physician

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ABILITY ASSESSMENT

Medical

	YES	NO	If Yes, please explain
Do you or have you ever had seizures?			
Are you visually impaired?			
Are you hearing impaired?			
Do you have bladder incontinence?			
Do you have bowels incontinence?			
Do you have affected use of any extremities?			
Do you have difficulty swallowing?			
Do you have problems affecting speech?			
Do you smoke?			

Mobility

	YES	NO	If Yes, please explain
Do you need assistance sitting down or standing?			
Do you need assistance walking up or down stairs?			
Do you need assistance opening doors?			
Do you need assistance picking up objects from the floor?			
Do you need assistance getting in or out of bed?			
Do you need assistance toileting?			
Please list any adaptive equipment used:			

Cognition

	YES	NO	If Yes, please explain
Do you have memory issues?			
Do you often get confused?			
Do you have problems with judgement?			
Do you trouble orienting to people or places?			
Do you have trouble with organization?			
Do you have trouble initiating activities?			
Other? (specify)			

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Emotional/behavioral adjustment

	YES	NO	If Yes, please explain
Do you have depression?			
Do you have anxiety?			
Do you have mood swings?			
Do you have feelings of paranoia?			
Do you have thoughts of suicide?			
Other? (specify)			
When angry or under stress,	**YES**	**NO**	**If Yes, please explain**
Do you swear at or threaten others?			
Do you physically attack others?			
Do you throw or break things?			
Do you do nothing?			
Do you run away?			
Other? (specify)			

Living skills

	YES	NO	If Yes, please explain
Do you need assistance bathing?			
Do you need assistance dressing?			
Do you need assistance eating?			
Do you need assistance writing?			
Do you need assistance using the telephone?			
Do you need assistance cleaning?			
Do you need assistance brushing teeth?			
Do you need assistance with hair, makeup of shaving?			
Other? (specify)			

Nutrition

	YES	NO	If Yes, please explain
Do you have specific nutrition requirements?			
Do you have specific food preparation requirements?			
Do you have food allergies?			
Describe your typical appetite (small, medium, large)			
Other? (specify)			

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SPECIAL NOTES

What are you hoping to accomplish? (Recreational, social, etc.)

Goal #1:
What actions will be necessary to achieve this goal?
1.
2.
3.
Goal #2:
What actions will be necessary to achieve this goal?
1.
2.
3.

SCHEDULE

The Adult Day Program is open 10:00am to 3:00pm, Monday to Friday. Choose preferred schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrive					
Depart					

BILLING

Participants will be billed only for actual days of attendance. Fees will not incur if participant misses a scheduled day for illness, vacation, or other reason. In the event of non-payment, participation in Adult Day Program may be suspended until the account is current.

Private Pay Rates

Provided upon request

Please check pay source:

_____ Private pay	Billing address:
_____ Medicaid	Case manager name & phone:
_____ VA	Case manager name & phone:
_____ Work Comp	Case manager name & phone:

Signature of Applicant	Printed Name	Date

Signature of Guardian	Printed Name	Date

ADULT DAY PROGRAM
Release of Confidential Information

I authorize and consent Hilltop to receive and provide confidential and pertinent information about the below named individual with the agencies or persons listed below. I understand that if I do not wish Hilltop to contact or exchange information with any of the below persons or agencies, I may cross them off. The information received and/or released shall be used solely for planning, coordinating and delivering the best and most appropriate services offered by Hilltop. I understand that I may cancel all or part of this consent by writing to Hilltop. I understand that if the person listed below commits a crime while participating with Hilltop or is accused of committing a crime or being a party to a crime, this release allows Hilltop to communicate information to applicable legal agencies in order to cooperate with all legal proceedings.

Applicant/Resident Name:	**DOB:**

Agencies/Vendors/People

Colorado Department of Health Care, Policy and Finance	Hilltop (Programs, staff, contracts, students)
Mesa County Department of Human Services	St. Mary's Hospital, St. Mary's Family Practice, and Affiliates
Marillac Clinic Services	St. Mary's Billing Department
Community Hospital and Affiliates	Grand Junction Police Department
Grand Junction Fire Department	NuMotion (Durable Medical Equipment)
Grand Mesa Medical Supply (Durable Medical Equipment)	Apria Health Care (Respiratory Supplies)
Omnicare Pharmacy	Rocky Mountain Health Plans
Other:	Other:

Family

Name	Relationship	Phone

Providers

Name	Relationship	Phone

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Other

Name	Relationship	Phone

I understand that these records are protected under Federal and State Confidentiality Regulations. This information cannot be disclosed without my written consent, unless otherwise specifically provided for in the Regulations. I understand that I may revoke this consent at any time, otherwise it shall continue in effect.

Signature of Applicant	Printed Name	Date

Signature of Guardian	Printed Name	Date

ADULT DAY PROGRAM
Health Status Inquiry

Participant: _____ Date:_____

Date of birth: _____ Age: _____ Social Security (last 4): _____

Physician office name:_____

Physician address: _____

Physician phone: _____Fax: _____

Hospital preference: _____Phone: _____

MEDICAL RELEASE

I hereby authorize (Physician's name printed)_____ to release the medical information below and any other pertinent information necessary for the care and health monitoring of the above named Participant to Hilltop's Adult Day Program.

Signature of Applicant	Printed Name	Date

Signature of Guardian	Printed Name	Date

PRIMARY CARE PROVIDER

Complete the below information and **ATTACH** a copy of the individual's current medication list.

Primary brain injury diagnosis:_____

Medical Diagnoses

Type/Cause	Approximate Date of Onset	Current Treatment

Over →

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Will prescription medications need to be administered by program staff? _____ Yes _____ No

Will over-the-counter medications need to be administered by program staff? _____ Yes _____ No

Do you recommend the specialized adult day care services for this patient? _____ Yes _____ No

Please explain: _____

Do you recommend any diet restrictions and/or specialized meals for this patient?

_____

Does this individual have any additional special health or behavioral management support needs?

_____

Does this individual required restriction in activities? _____ Yes _____ No

Please explain: _____

Additional Comments:

_____

_____

_____

_____

_____

Signature of Physician | Printed Name | Date