**Tswv Chao Vang Center, LLC./ INTEREST FORM 11010 W. Hampton Ave. Milwaukee, WI 53225**

PROFILE TRIAL DATE #1 : / / TRIAL DATE #2 : / /

Ph#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

Social Security:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female

US Citizen  Lawful permanent resident  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of years in the US \_\_\_\_\_\_\_\_\_

Residential Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip \_\_\_\_\_

**Marital Status**: Legally Married/Divorced/Seperated/Widow Spouse Name: \_\_\_\_\_\_\_ Spouse’s Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant:** Type of income: Social Security Retirement $\_\_\_\_\_\_\_\_\_\_ Supplement Security Income $\_\_\_\_\_\_\_\_\_\_ Social Security Disability Insurance $\_\_\_\_\_\_\_\_\_\_\_\_Pension $\_\_\_\_\_\_\_\_\_\_\_\_ Other:$\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse if applicable:** Type of income: Social Security Retirement $\_\_\_\_\_\_\_\_\_\_Supplement Security Income $\_\_\_\_\_

Social Security Disability Insurance $\_\_\_\_\_\_\_\_\_\_\_\_Pension $\_\_\_\_\_\_\_\_\_\_\_\_ Other:$\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare# Other Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_

If other: How much is the monthly premium:$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Transportation:**  Tswv Vang Center, LLC.  Participant will provide his/her own transportation

Pick up location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Business/School/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drop off location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Business/School/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Transportation, breakfast, lunch, PM snack, coffee, tea, and water are included during your trial period at no charge. You are more than welcome to bring your own meals and provide your own transportation if you prefer.***

CHARACTERISTICS: Religion \_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_ Height ft. \_\_\_\_\_\_ in.

Primary Language:  English  Hmong  Lao  Burmese  Karen  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTHCARE INFORMATION DNR:  Yes  No

Family Dr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Dr Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: Dairy Coconut Peanuts Soy Seafood Fish Pork Beef Chicken Latex Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergens: Participants with food allergies. Please be aware that our food may contain or come into contact with common allergens, such as dairy, eggs, wheat, soybeans, tree nuts, peanuts, fish, shellfish, or wheat.**

Dietary / Special Needs: Prudent/Diabetic (low fat, low cholesterol, low sodium, high fiber, No Concentrated Sweet aka NCS)/Puree/Chopped/No Caffeine allowed

Medical Notes and Diagnosis:

Wanders: \_\_\_Yes \_\_\_\_ No

Other:

Mobility Devices(s) Cane/Wheel Chair: Manual or Electric/Walker/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently enrolled at another Adult Day Care? Y or N If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of discharged? \_\_\_\_\_\_\_\_\_\_

Are you currently enrolled in Family Care or an IRIS? Y or N Name of agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consultant name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Utilize a home health care? Y N, If yes name of Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Utilize supportive care? Y N, If yes name of Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_\_\_

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

ADLs – ACTIVITIES OF DAILY LIVING: (Do you need help with the below when you are here at the Center)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Monitor Ambulation |  | Encourage Fluids |
|  | Toileting Assistance |  | Assist w/Dressing & Undressing |
|  | Incontinence Care |  | Other |
|  | Help with eating |  | Other |
|  | Support Self-Administered Meds |  | Other |

AUTHORIZATION FOR DISPENSING MEDICATIONS

**All prescribed medications that have been prescribed by a physician and needing assistance from the staff at Tswv Chao Vang Center, LLC. with medication dispensing must complete the following authorization below. Non-prescription medicines, such as aspirin, Motrin, Tylenol, and antacids may be given (PRN) according to label directions if we have this signed authorization from the participant, participant's physician, or legal representative. Medications must be adequately identified. The drug must be labeled with the medication name and dosage or be in its original container.**

I hereby  authorize  DO NOT authorize the staff (RN or trained personnel) of Tswv Chao Vang Center LLC. to administer the medication(s) listed below.  I am capable to self-administer my medications with my Dr.'s approval. See attached.  I will take my medication(s) at home before I attend the Center independently or with the help of family members or friends.

I hereby release Tswv Chao Vang Center LLC.'s officers, staff, and personnel from any and all liability that might arise due to the medication being administered and hereby waive any action that I may have as a result of the drug being managed by their staff or by myself. I will notify the team at Tswv Chao Vang Center LLC. if my medicine supply is low. Future, I release the foresaid from any and all liability that might arise due to said medication not being administered because the amount was not replenished.

List the prescribed medications or over the counter medications that will be taken at the Center. If you need additional space, please ask the staff for another form.

**Signature of Participant/Legal representative Date Signed:**

List the prescribed and OTC medications that will be taken at the Center.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Medication | Dosage | Frequency | Route | Time Given at Program | Notes |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
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PARTICIPANT'S RIGHTS

All participants at Tswv Chao Vang Center LLC. shall:

Be treated with respect and dignity.

Be free from physical or verbal abuse.

Participate in developing one's service plan, with support from staff or significant other if needed.

Refuse to participate in any particular activity.

Privacy and confidentiality

Be fully informed of all the services provided and the charge for each of those services.

Be informed of the reason for discharge and the procedure for appealing that decision.

Initiate a complaint and be informed of the complaint procedure.

PHOTO RELEASE

I grant Tswv Chao Vang Center, LLC. permission to use my likeness in photographs and/or video in any and all of its publications, including social media (Facebook, Instagram, Twitter, etc.), and in any and all other media, whether now known or hereafter existing, controlled by Tswv Chao Vang Center LLC., in perpetuity, and for further use by the Center. I will make no monetary or other claims against Tswv Chao Vang Center LLC., for the photographs and/or video. I understand this release can be withdrawn at any time.

LIABILITY RELEASE

The undersigned hereby releases Tswv Chao Vang Center LLC., and all of its officers, directors, employees, staff, and volunteers of and from any and all claims for injury, losses, costs, and expenses incurred by the undersigned or the Guest from any accident, injury, illness or damage of personal property suffered or incurred in connection with any services, programs or care provided or performed by Tswv Chao Vang Center LLC.

In case of emergency, I hereby permit Tswv Chao Vang Center LLC., its staff, employees, and volunteers to summon or perform emergency services for the participant and/or arrange transportation to the most available hospital. I understand that such emergency, hospital, or physician services will be billed directly to me. Tswv Chao Vang Center LLC., will not be held responsible for payment of such services.

**The Participants Rights, Photo Release, and Liability Release information have been thoroughly explained to me, and I fully understand it. I certify that the information submitted on this application is true and correct to the best of my knowledge.  I further understand that any false statements may result in denial to be part of the Tswv Chao Vang Center, LLC. My signature below confirms this acknowledgment.**

**Signature of Participant/Legal representative Date Signed:**

**Signature of Tswv Chao Vang Center, LLC. Staff Date Signed:**