Sunrise
Adult Activity & Health Center
We Are Your Family Outside the Home

9525 Wilcrest Drive Houston, TX 770
Tel: 832-379-3795 | Direct: 832-794-21
Fax: 281-858-20
Email: sunriseactivity@yahoo.co
www.sunriseactivity.co

CLIENT FILE

OUTSIDE COVER – CLIENT ID

LEFT SIDE

1. Application for Service
2. Client Intake and Service Request
3. CACFP Meal Benefit Income Eligibility Form
4. Statement of Client's Rights
5. How to file Complaint
6. Waiver of Liability
7. Consent for Treatment & Emergency treatment release
8. Photograph & advertisement release

RIGHT SIDE

1. Vital Signs Sheet
2. Nurse Assessment Form
3. Physician Orders
4. Summary of Client's Need for Services
5. Authorization for Community Case Services
6. Physician's Orders
7. Health Assessment/Individual Service Plan

Sunrise
Adult Activity & Health

9525 Wilcrest Drive, Houston, TX 77099

APPLICATION FOR SERVICES

GENERAL INFORMATION

DATE OF APPLICATION: _____

NAME OF APPLCANT: _____
LAST NAME FIRST NAME MIDDLE NAME

PRESENT ADDRESS: STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS (PLEASE CHECK) _____ SINGLE _____ MARRIED _____DIVORCED ____ WIDOWED

PRIMARY LANGUAGE (PLEASE CHECK) _____ ENGLISH _____ SPANISH _____ OTHER; SPECIFY: ____

COMMUNICATION MODE (PLEASE CHECK) _____VERBAL _____ GESTURES _____ VOCALIZATIONS

_____ SIGN LANGUAGE _____DEVICE(S) (SPECIFY) _____

NAME OF CONTACT, *IF OTHER THAN APPLICANT*

LAST NAME: _____ FIRST NAME: _____

RELATIONSHIP TO APPLICANT: _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

GENERAL PROGRAM INFORMATION

DAYS REQUESTING ATTENDANCE (PLEASE CIRCLE ALL THAT APPLIES) M T W TH F

TIMES REQUESTING ATTENDANCE: START TIME: _____ END TIME:_____

TRANSPORTATION TO AND FROM DAY CARE: (PLEASE CHECK)

_____PERSONAL _____METROLIFT _____PROGRAM TRANSPORT

PARTICIPATING MEALS (PLEASE CIRCLE ALL THAT APPLIES)

B /A.M SNACK/ LUNCH/ P.M SNACK/ DINNER

APPLICATION FOR SERVICES

Name: _____ Date of Birth: _____ Date of Arrival: _____

BACKGROUND INFORMATION

PLACE OF BIRTH: City: _____ County: _____ State: _____

US CITIZENSHIP (PLEASE CHECK) _____ y _____N ETHNICITY: _____ RELIGON: _____

LEGAL STATUS (PLEASE CHECK) _____ COMPETENT _____ INCAPACITATED (COURT APPOINTED GUARD)

If has a Guardian:

Name of Guardian: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Other/ Emergency: _____

Date Appointed by Court: _____ Court Case Number: _____

County: _____ State: _____

INSURANCE INFORMATION

MEDICAID (PLEASE CHECK)

___ Y, NUMBER (#) _____

___ N, HAVE APPLIED AND BEEN DENIED

___ NM HAVE NEVER APPLIED

OTHER SOURCES (PLEASE CHECK)

___ UNITED HEALTHCARE ___ AMERIGROUP ___MOLINIA ___ OTHER

(IF CHECKED) PLEASE PROVIDE INFORMATION

POLICY NUMBER (#) _____ GROUP NUMBER (#) _____

(PLEASE PROVIDE A COPY OF INSURANCE CARD CHECKED ABOVE)

APPLICATION FOR SERVICES

Name: _____ Date of Birth: _____ Date of Arrival: _____

APPLICANT INCOME

ESTIMATED ANNUAL INCOME OF APPLICANT: _____

PRIMARY SOURCE OF INCOME: (PLEASE CHECK) ____SSI _____WAGES _____ OTHER _____

OTHER MEANS OF FINANCIAL SUPPORT _____

FAMILY/ CONTACTS

NAME OF FATHER: _____

DESCRIBE CONTACT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

NAME OF MOTHER: _____

DESCRIBE CONTACT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP TO APPLICANT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

NAME OF EMERGENCY CONTACT: _____

DESCRIBE CONTACT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

APPLICATION FOR SERVICES

Name: _____ Date of Birth: _____ Date of Arrival: _____

MOBILITY/SELF CARE

DESCRIBE APPLICANT'S PARTICIPATION IN COMMUNITY/ NEIGHBORHOOD:

_____

_____

_____

_____

MOBILITY (PLEASE CHECK ONE)

_____ **WALKS INDEPENDENTLY** _____ **WALKS WITH ASSISTANCE FROM OTHERES**

_____ **USES WHEELCHAIR INDEPENDENTLY** _____**USES WHEELCHAIR WITH ASSISTANCE FROM OTHERS**

DESCRIBE/ LIST ANY ADAPTIVE EQUIPMENT USED FOR MOBILITY: _____

_____

_____

DESCRIBE ASSISTANCE NEEDED TO GET FROM ONE PLACE TO ANOTHER: _____

_____

_____

EATS MEAL INDEPENDENTLY: ____Y ____N (NO, PLEASE DESCRIBE HELP NEEDED: _____

BATH MEAL INDEPENDENTLY: ____Y ____N (NO, PLEASE DESCRIBE HELP NEEDED: _____

DRESSES MEAL INDEPENDENTLY: ____Y ____N (NO, PLEASE DESCRIBE HELP NEEDED: _____

REST ROOM INDEPENDENTLY: ____Y ____N (NO, PLEASE DESCRIBE HELP NEEDED: _____

DESCRIBE ANY OTHER ASSISTANCE NEEDED/COMMENTS: _____

_____

_____

_____

_____

_____

APPLICATION FOR SERVICES

Name: _____ Date of Birth: _____ Date of Arrival: _____

INTERACTIONS

DESCRIBE HOW APPLICANT INTERACTS WITH OTHERS: _____

_____

_____

DESCRIBE BEST WAY TO INTERACT WITH OTHERS: _____

_____

_____

DESCRIBE THINGS THAT THE APPLICANT LIKES OR THAT MOTIVATE THAT MOTIVATE HIM/HER:

_____

_____

_____

DESCRIBE APPLICANT'S ABILITY TO MAKE CHOICE: _____

_____

_____

DESCRIBE ANY SIGNIFICANT BEHAVIORS: _____

_____

_____

MEDICAL

PRIMARY PHYSICIAN: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

KNOWN ALLERGIES (FOOD, MEDICATION, OTHER): _____

_____

EXISTING MEDICAL CONDITIONS/DIAGNOSES: _____

_____

I AGREE THAT THE INFORMATION PROVIDED IS, TO THE BEST OF MY ABILITY, ACCURATE AND COMPLETE.

APPLICANT SIGNATURE: _____ **GUARDIAN SIGNATURE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

TEXAS
Department of Aging and Disability Services

Form 2276
March 2014-E

Client Intake and Service Request

Area Agency on Aging of _____

The information on this form is required by your local service provider, the Area Agency on Aging (AAA), and the Texas Department of Aging and Disability Services. All information provided will be kept confidential and guarded against unofficial use. Information gathered through an intake or through an assessment may be shared to effectively plan, arrange and deliver services to meet an individual's needs.

☐ **Release of information has been clearly explained to the individual.**

Date	Individual's ID Number	Individual's Primary Language		
Last Name	First Name			MI
Street Address/Apt No.	City	State	ZIP Code	County
Area Code and Telephone No.	Birth Date	Gender ☐ Male ☐ Female		

Ethnicity (Check One):
- ☐ (1) Hispanic or Latino
- ☐ (2) Not Hispanic or Latino
- ☐ (3) Ethnicity Not Reported

Race (Check all that apply):
- ☐ (1) White – Non Hispanic
- ☐ (2) White – Hispanic
- ☐ (3) American Indian/Alaska Native
- ☐ (4) Asian
- ☐ (5) Black or African American
- ☐ (6) Native Hawaiian or Pacific Islander
- ☐ (7) Persons Reporting Some Other Race
- ☐ (8) Race Not Reported

Marital Status (Check One):
- ☐ (1) Married
- ☐ (2) Widowed
- ☐ (3) Divorced
- ☐ (4) Separated
- ☐ (5) Never Married
- ☐ (6) Not Reported

Does individual live alone? ☐ **Yes** ☐ **No**

Total Number of Family Members in Household Including Individual: _____

Monthly Household Income: _____ ☐ Low Income ☐ Moderate Income ☐ High Income

Low Income Levels for: Single person family unit – $ 11,490; Two person family unit – $15,510; Add $4,020 for each additional person

Monthly Income from:	**Individual**	**Spouse**
Job		
Social Security		
Supplemental Security Income		
Veterans Affairs		
Other Sources		
Other Benefits (e.g., Supplemental Nutritional Assistance Program (SNAP))		

Emergency Contact Information

Contact Name	Relationship	Area Code and Telephone No.
Primary Care Physician	Area Code and Telephone No.	
Service(s) Requested		

Are you enrolled in? ☐ Medicare Medicare No.: _____ ☐ Medicaid Medicaid No.: _____

Referred By

- ☐ Texas Department of Family and Protective Services (DFPS)
- ☐ Texas Department of Assistive and Rehabilitative Services (DARS)
- ☐ Texas Department of State Health Services (DSHS)
- ☐ Doctor ☐ Hospital ☐ Assisted Living Facility
- ☐ Home and Community Care Organization
- ☐ Family Member
- ☐ Other

_____ _____
Signature – AAA/Provider Staff Completing Intake Date

To be completed by AAA/Provider Staff

Nutrition Services: If participant is "other Older Americans Act (OAA) or NSIP eligible participant under 60 year of age," check which of the following applies:

- ☐ (1) Spouse is eligible and participates at the nutrition site
- ☐ (2) Serves as volunteer at the nutrition site in accordance with OAA standards.
- ☐ (3) Disabled/resides in the housing facility and wants to participate in the congregate meal program provided at the site.
- ☐ (4) Disabled and lives with the person participating in the congregate meal program.

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Part 1. All Household Members

Name of Enrolled Adult(s):

Names of Household Members (including enrolled adult(s)) (First, Middle Initial, Last)	CHECK IF NO INCOME
	☐
	☐
	☐

Part 2. Benefits: If any member of your household receives SNAP, TANF, FDPIR, SSI or Medicaid, provide the name and case number for the 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** participant(s), spouse and dependent children of participant(s) with income)	**B. Gross income and how often it was received**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$200/bi-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 must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give. I understand that CACFP officials may verify 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)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

. CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Don't fill out this part. This is for official use only Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____
Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

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STATEMENT OF CLIENT RIGHTS

Participants of Sunrise Adult Activity & Health Center, LLC. Are entitled to the following rights as required by the National Council on The Aging, Inc.:

1. The right to be treated as an adult, with dignity and respect.

2. The right to participate in a program of services and activities that promote positive attitudes regarding their usefulness and capabilities.

3. The right to participate in a program of services to encourage learning, growth, and awareness of constructive ways to develop their interest and talents.

4. The right to be encouraged and supported in their independence to the extent that conditions and circumstance permit, and to be involved in a program of services designed to promote personal independence.

5. The right to self-determination with the day care setting, including the opportunity to:

    a. Participate in developing their own service plan.

    b. Decide whether or not to participate in any given activity.

    c. Be involved to the fullest extent possible in program planning and operation.

6. The right to be cared about in an atmosphere of sincere interest and concern in which services are provided.

7. The right to privacy and confidentiality.

_____ _____

Signature Date

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TEXAS DEPARTMENT OF HUMAN SERVICES

The Texas Department of Human Services hope that you and your loved ones are satisfied with the care provided at the facility.

However, if you are dissatisfied, we urge you to voice your complaints to the Director of this facility, AND/OR:

Call the Texas Department of Human Services at the Toll- Free telephone number listed below:

To file a COMPLAINT
CALL 1-800-458-9858

For Facility INFORMATION
CALL 1-800-458-9858

For Assistance CALL
THE CONSUMER ADVOCATE
1-800-252-8016

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WAIVER OF LIABLITY

I, _____ UNDERSTAND and ACKNOWLEDGE THAT UPON LEAVING the Facility of Sunrise Adult Activity & Health Center, LLC, I must sign the sign-out sheet. Upon leaving, I release Sunrise Adult Activity & Health Center, LLC of all liability related to any and all injury on myself.

Additionally, if I leave Sunrise Adult Activity & Health Center, LLC and do not inform the staff of Sunrise Adult Activity & Health Center, LLC, I also release Sunrise Adult Activity & Health Center, LLC of all liability related to any and all injury to myself.

_____ _____

Signature Date

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CONSENT FOR TREATMENT AND EMERGENCY TREATMENT RELEASE

I, _____ hereby authorize Sunrise Adult Activity & Health Center, LLC employees, emergency medical personal, and the hospital, to perform emergency first aid treatment as needed for me to be stabilized in case I am not able to authorize such treatment at the time of an emergency accident or illness.

_____ _____

Signature of Client/Guardian Date

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PHOTOGRAPH AND ADVERTISEMENT RELEASE

I, _____ hereby GIVE Sunrise Adult Activity & Health Center, LLC permission to take my photograph and to display it in the Facility, as well as in the newspaper to record special events or promotions of the Facility.

_____ _____

Signature of Client/Guardian Date

_____

Witness

Sunrise Adult Activity & Health Center, LLC
Vital Signs Sheet

CLIENT:	Notes:
DOB:	
M/F:	
RN/LVN:	

Date	Weight	Temp.	BP	Pulse	Respiration	Pain	Initials

Texas Department of Aging and Disability Services

CBA Semiannual Nursing Assessment Attachment

Form 3751-A
January 2012

Individual Name: _____ **Room:** _____ **Date:** _____

ACTIVITIES OF DAILY LIVING

Bed Mobility: (Describe for status in the last 7 days. Check for most dependent status occurring 3 or more times.)

Did individual participate in activity? ☐ **Yes** ☐ **No**

The most assistance provided was:
- ☐ None (Individual independent in performing activity)
- ☐ Verbal (Encouragement, Cueing, Standby)
- ☐ Non Weight Bearing Physical (Guiding, Maneuvering)
- ☐ Weight Bearing (Assistance bearing physical weight)
- ☐ Total – Check only if individual non-participatory

Most Amount of Assistance:
☐ None ☐ Set up only ☐ One person physical assistance ☐ Two (+) persons physical assistance

Is the individual **bedfast** (bed or recliner in room 22 out of 24 hours per day for 4 of the last 7 days)? ☐ **Yes** ☐ **No**

Describe why individual needs assistance:

_____

Does ability to perform activity vary? (Cognitive changes, Fatigue, Acute episode)
☐ **Yes** **Why:** _____
☐ **No**

Transferring: (Describe for status in the last 7 days. Check for most dependent status occurring 3 or more times.)

Exclude transfers for toileting and baths.

Did individual participate in activity? ☐ **Yes** ☐ **No**

The most assistance provided was:
- ☐ None (Individual independent in performing activity)
- ☐ Verbal (Encouragement, Cueing, Standby)
- ☐ Non Weight Bearing Physical (Guiding, Maneuvering)
- ☐ Weight Bearing (Assistance bearing physical weight)
- ☐ Total – Check only if individual non-participatory

Most Amount of Assistance:
☐ None ☐ Set up only ☐ One person physical assistance ☐ Two (+) persons physical assistance

Describe why individual needs assistance:

_____

Does ability to perform activity vary? (Cognitive changes, Fatigue, Acute episode)
☐ **Yes** **Why:** _____
☐ **No**

Any **acute episode** affecting transferring? ☐ **No** ☐ **Yes** **Describe:** _____

Eating: (Describe for status in the last 7 days. Check for most dependent status occurring 3 or more times.)

Check one: ☐ Oral ☐ Tube fed ☐ Both oral and tube feedings

Did individual participate in activity? ☐ **Yes** ☐ **No**

The most assistance provided was:
- ☐ None (Individual independent in performing activity)
- ☐ Verbal (Encouragement, Cueing, Standby)
- ☐ Non Weight Bearing Physical (Guiding, Maneuvering)
- ☐ Spoon fed part or all of meal/Tube feeding by staff but participated in eating process
- ☐ Total – Check only if individual non-participatory

Most Amount of Assistance:
☐ None ☐ Set up only ☐ One person physical assistance ☐ Two (+) persons physical assistance

Describe why individual needs assistance:

_____

Does ability to perform activity vary? (Cognitive changes, Fatigue, Acute episode)
☐ **Yes** **Why:** _____
☐ **No**

Any **acute episode?** ☐ **No** ☐ **Yes** **Describe:** ☐ Nausea ☐ Emesis: **Amt.** ☐ Small ☐ Moderate ☐ Large
Color: ☐ Clear ☐ White ☐ Yellow ☐ Green ☐ Blood ☐ Brown ☐ Coffee Ground ☐ Food ☐ Guiac +
☐ **Pain:** ☐ Sharp ☐ Burning ☐ Dull/Ache **Location:** ☐ Left Upper ☐ Right Upper ☐ Left Lower ☐ Right Lower
☐ **Other:** **Describe:** (Difficulty chewing, swallowing, etc.) _____

Has there been a significant weight loss? (5% in 30 days or 10% in the last 180 days?) ☐ **No** ☐ **Yes**

Toileting: (Describe for status in the last 7 days. Check for most dependent status occurring 3 or more times.)

Check all that apply: ☐ BR ☐ BSC ☐ BP ☐ Urinal ☐ Cath/Ostomy ☐ Incont. Care: _____ Bladder _____ BM

Did individual participate in activity? ☐ **Yes** ☐ **No**

The most assistance provided was:
- ☐ None (Individual independent in performing activity)
- ☐ Verbal (Encouragement, Cueing, Standby)
- ☐ Non Weight Bearing Physical (Guiding, Maneuvering)
- ☐ Weight Bearing (Assistance bearing physical weight)
- ☐ Total – Check only if individual non-participatory

Most Amount of Assistance:

☐ None ☐ Set up only ☐ One person physical assistance ☐ Two (+) persons physical assistance

Frequency of Incontinence: Bladder: ☐ None ☐ Less than daily ☐ Daily, some control ☐ Daily, no control

Bowel: ☐ None ☐ Less than weekly ☐ Weekly, 1 or more ☐ Daily

Describe why individual needs assistance:

Does need for help vary? (Difference between Bladder/Bowel; Cognitive changes, Fatigue, Acute episode)

☐ **No** ☐ **Yes – Why:**

Is individual on scheduled toileting? ☐ **No** ☐ **Yes Describe:**

Is individual on bladder retraining? ☐ **No** ☐ **Yes Describe:**

Any **acute bowel episodes?** ☐ **No** ☐ **Yes** **Check all that apply.**

(Assess BS, Abd. tone, Pain – nature and location, Color and Consistency of Stool) ☐ Constipation ☐ Impaction ☐ Diarrhea

Describe:

Any **acute urinary symptoms?** ☐ **No** ☐ **Yes** **Check all that apply.** ☐ Urgency ☐ Frequency

Urine: **Color:** _____ ☐ Clear ☐ Cloudy ☐ Bloody **Odor:** ☐ None ☐ Foul ☐ Strong

Pain: ☐ None ☐ Burning ☐ Sharp ☐ Dull/Ache ☐ When voiding ☐ Where:

Other:

Skin Assessment:

Color: ☐ WNL ☐ Pale ☐ Flushed ☐ Cyanotic ☐ Hot ☐ Warm ☐ Cool ☐ Cold ☐ Dry ☐ Diaphoretic ☐ Clammy

Mucous Membranes: ☐ Dry ☐ Moist

Integrity: ☐ Intact ☐ Not-Intact (If multiple sites, use additional sheets.)

☐ Bruise ☐ Rash ☐ Skin Tear ☐ Burn: Degree _____

☐ Laceration ☐ Surgical Wound ☐ Other Wound

☐ Ulcer (If more than one ulcer, use additional pages to describe.)

Size: _____ Stage: _____ Color: _____ ☐ Necrosis ☐ Eschar

Drainage: ☐ None ☐ Yes – Amount: ☐ Small ☐ Moderate ☐ Large

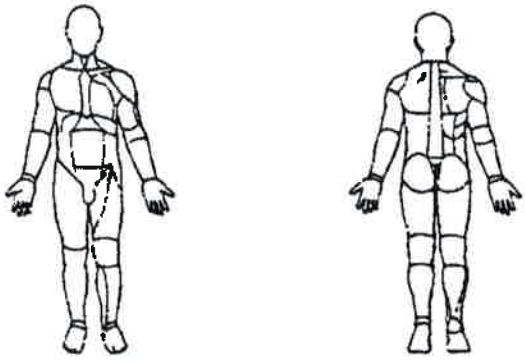
Color: ☐ Clear ☐ White ☐ Yellow ☐ Green ☐ Bloody

Odor: ☐ None ☐ Yes: **Describe:**

Tunneling: ☐ **No** ☐ **Yes**

☐ **Turgor:** Describe:

☐ **Edema:** Where: _____ Amt.: _____ +



Vital Signs: Temp: _____ B/P: _____ Pulse: _____ Resp: _____

SOB: ☐ No ☐ Yes (*assess breath sounds): ☐ At rest ☐ Lying down ☐ With exertion ☐ All the time

Chest Pain: ☐ No ☐ Yes (*assess breath sounds): **Describe:**

Cough: ☐ No ☐ Yes (*assess breath sounds): ☐ Dry ☐ Wet ☐ Loose ☐ Tight ☐ Rattling

***Breath sounds: Describe:**

Secretions: ☐ No ☐ Yes – ☐ Cough ☐ Suction **Amt.:** ☐ Small ☐ Moderate ☐ Large **Consistency:** ☐ Thin ☐ Thick

Color: ☐ Clear ☐ White ☐ Yellow ☐ Green ☐ Bloody ☐ Brown ☐ Other:

Psycho-Social: ***Memory: Short Term*** ☐ Intact ☐ Impaired ***Oriented to:***

Decision making: ☐ Appropriate ☐ Cueing/Supervision needed ☐ None

Mood State Indicators: ***Verbal expressions of distress*** (Negative statements, Repetitive questions/statements, Anger with self or others, Self-depreciation, Expresses unrealistic fears, Repetitive statements something terrible is about to happen. Repetitive health or other complaints)

☐ **No** ☐ **Yes – Describe:**

Physical Manifestations of Distress: (Unpleasant mood in morning, Insomnia, Change in sleep pattern, Sad/Pained affect, Crying/tearfulness, Repetitive movements, Withdrawal activities on interest, Reduced social interaction)

☐ **No** ☐ **Yes – Describe:**

Are there changes in cognition or mood since last assessment? ☐ **No** ☐ **Yes – Changes last 7 days?** ☐ **No** ☐ **Yes**

RN Signature: _____ **Date:** _____

CBA Semiannual Nursing Assessment (cont.)

Behavior Patterns

Code for Status Last 7 Days

0 – None 1– Behavior Occurred Less Than Daily 2 – Behavior Occurred Daily

_____ Verbal Aggression _____ Physical Aggression _____ Other Socially Inappropriate _____ Resists Care

Diagnosis

List any NEW DIAGNOSES in the last 3 months which are still affecting care needs.

1. _____
2. _____
3. _____
4. _____

Health Conditions

Check any conditions occurring in the last 7 days.

- ☐ Inability to lie flat due to shortness of breath
- ☐ Delusions
- ☐ Hallucinations
- ☐ Fever
- ☐ Pain – If checked, was pain: ☐ Less than daily ☐ Daily ☐ Multiple times a day Highest Severity was: ☐ Mild ☐ Moderate ☐ Severe
- ☐ Fall in last 30 days
- ☐ Fall in last 180 days
- ☐ Hip fracture in last 180 days
- ☐ Other fracture in last 180 days
- ☐ Dehydrated
- ☐ Dizziness / Vertigo
- ☐ Syncope
- ☐ Unsteady gait

Dietary

Diet: _____ Is Mechanical Alteration Used? ☐ **No** ☐ **Yes** _____

Has there been a change in the last 90 days? ☐ **No** ☐ **Yes** _____

Treatments and Health Interventions

_____ **Number of medications last 7 days** **New medications last 3 months?** ☐ **No** ☐ **Yes**

Check for any used in last 2 weeks:

☐ Chemotherapy ☐ Radiation ☐ Dialysis ☐ IV Fluids ☐ IV Medications ☐ Transfusions

☐ Oxygen ☐ Suctioning ☐ Trach. Care ☐ Ventilator/Respirator

Restraints: (Code whether device is used for positioning or restraint) 0 – Not Used 1– Used Less Than Daily 2 – Used Daily

_____ Bed rails _____ Trunk restraint _____ Limb restraint _____ Chair prevents rising

Code Number of Times Client was:

_____ Hospitalized for an overnight stay or longer in the last 3 months.

_____ Seen in **emergency room** in the last 3 months.

_____ Seen by physician (excluding hospital stays) in the last 14 days.

Have there been abnormal lab values/test results in the last 3 months? ☐ **No** ☐ **Yes – What:** _____

Medications

List All Medications for the Last 7 Days

Code for Route of Administration: 1 – Oral 2 – SL 3 – IM 4 – IV 5 – SQ 6 – Rectal 7 – Topical 8 – Inhalation 9 – Enteral 10 – Other

For PRN: Indicate the number of doses received in last 7 days

Medication Name and Dose	Route	Frequency	PRN — #

Comments:

RN Signature: _____ **Date:** _____

Texas Department of Aging
and Disability Services

Summary of Client's Need for Service

(Auto) Form 2059
September 2009

Client No.: Client Name:

Action Type: Assessment Date:

1. Conditions which cause functional limitations:

2. Why is client unable to perform, or is limited in, activities of daily living?

3. Description of client's home environment:

Residence
- ☐ In town/suburb
- ☐ Rural area, easily accessible
- ☐ Rural area, difficult to access
- ☐ Isolated
- ☐ No residence
- ☐ Other:

Laundry
- ☐ Washer and Dryer
- ☐ Washer only
- ☐ Neither

Adequate
- ☐ Home equipped with electricity, heat, water, and plumbing

Miscellaneous
- ☐ Special-equipped vehicle for transport

Assistive Devices
- ☐ Ramp
- ☐ Hospital Bed
- ☐ Grab bars
- ☐ Portable toilet
- ☐ Other:

Other – Comments:

Explanation of specific problems that impact service delivery:

Unsafe
- ☐ Unsanitary
- ☐ Severe state of disrepair
- ☐ Other:

Questionable
- ☐ No water
- ☐ No plumbing/needs major repairs
- ☐ No electricity
- ☐ No A/C or fan
- ☐ No telephone
- ☐ Extreme clutter
- ☐ Dangerous pets
- ☐ Other:

4. Client's Living Arrangement:

5. Explanation of current and ongoing role of family or caregiver in meeting client's needs:

Support Name	Primary Support Type	Reason Why Need of Client Cannot Be Met

6. Common Household Task(s) being purchased and the reason:

7. What other services is client currently receiving or being referred for?

8. Agency(ies) Selected:

Service:	Provider ID:	Provider DBA Name:	Method of Selection:

Printed: **User:**

Texas Department of Aging
and Disability Services

Form 2101
July 2013-E

Authorization for Community Care Services

Service Name:

1. Date	2. Contract Number	3. Type of Authorization ☐ 1 New ☐ 2 Update ☐ 3 Terminate		4. Begin Date	5. End Date	6. Term Code
7. Individual Name		8. Individual Number	9. 2060 Score	10. Priority	11. County	12. Agency 324

13. Provider Address	SERVICE						COPAYMENT		
	14. RUG	15. Fund Code	16. Group 7	17. Code	18. Units	19. Unit Type	20. Initial Amount	21. Ongoing Amount	22. % CMPAS Only

23a. For **PAS** check one: ☐ **CAS** ☐ **PHC** ☐ **FC**	Check if CDS ☐ **CDS**	23b. For **DAHS** check one: ☐ **Title XIX** ☐ **Title XX**

24. Service Items - Personal Assistance Services Only (check all that apply):

☐ 01 Bathing	☐ 04 Feeding/Eating	☐ 08 Toileting	☐ 12 Cleaning	☐ 15 Escort
☐ 02 Dressing	☐ 06 Grooming/Shaving/Oral Care	☐ 10 Transfer	☐ 13 Laundry	☐ 16 Shopping
☐ 03 Exercise	☐ 07 Routine Hair/Skin Care	☐ 11 Walking	☐ 14 Meal Preparation	☐ 17 Assist with Self-Administered Medication

25. Comments:

Authorizing Agents (as applicable)

26. Case Manager	27. Telephone Number (with area code and extension)	28. Mail Code	29. BJN
30. Case Manager Address			
31. Practitioner	32. Telephone Number (with area code and extension)	33. License No	34. Date of Order
35. Nurse	36. Telephone Number (with area code and extension)	37. Mail Code	38. BJN
39. Nurse Address			

40. Diagnosis:

Contracted Agency May Complete This Section and Return a Copy to DADS ..... Service Initiation Date _____

Schedule	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total Hours

Agency Contact Person	Telephone No. (with area code and ext.)

Comments:

_____ Signature — Agency Representative

_____ Date

Texas Department of Aging and Disability Services

Case Information

Form 2067
December 2012-E

To:

From:

Mail Code: _____

Mail Code: _____

Case Name	Category	Case No.	Category	Case No.

Address (Street, City, State, ZIP Code)	Area Code and Telephone No.

Please check all that apply.

- ☐ Absent Parent
- ☐ Change in Address/ Telephone
- ☐ Change in Circumstances
- ☐ Child Care
- ☐ Community Placement Resources
- ☐ Deductions
- ☐ Employment Services
- ☐ EPSDT
- ☐ Family Health Services Nurse
- ☐ Family Planning
- ☐ Household Composition
- ☐ Income
- ☐ LTSS Information Shared
- ☐ Medicaid
- ☐ Medical/Disability
- ☐ MERP Shared
- ☐ Nursing Care/Level of Care
- ☐ Protective Services
- ☐ Refugee Services
- ☐ Resources
- ☐ Support Services
- ☐ TANF
- ☐ Other _____

Comments/Response

Area Code and Telephone No.

_____ Signature

_____ Date

Response

To:

From:

Mail Code: _____

Mail Code: _____

Comments/Response

Area Code and Telephone No.

_____ Signature

_____ Date

TEXAS
Department of Aging and Disability Services

Form 3055
October 2015-E

Day Activity and Health Services (DAHS)

Physician's Orders

Day Activity and Health Services (DAHS) is a licensed day care program for the aged and/or disabled administered by the Texas Department of Aging and Disability Services. The program provider must have services available for eligible individuals at least 10 hours per day, Monday through Friday, except holidays. Services include licensed nursing care, planned activities, hot lunch and mid-morning/afternoon snacks, personal care assistance, transportation to and from the facility, therapies and treatments.

Section I. Individual Information

Individual Name (Last, First, Middle Initial)	Date of Birth	Individual No.
DAHS Facility Name	DAHS Nurse	DAHS Area Code and Telephone No.
DAHS Facility Address (Street, City, State and ZIP Code)		

Section II. List Chronic Medical Diagnoses from the Last 24 Months

Section III. Functional Limitations Related to Medical Diagnoses

- ☐ Behavior/Emotional Problems
- ☐ Contractors
- ☐ Incontinence
- ☐ Spasticity
- ☐ Pain
- ☐ Blackouts
- ☐ Dizziness
- ☐ Hearing Impairment
- ☐ Nausea
- ☐ Shortness of Breath
- ☐ Vision Impairment
- ☐ Falls Easily
- ☐ Difficulty Swallowing
- ☐ Limited Dexterity
- ☐ Hearing Impairment
- ☐ Tremors
- ☐ Unable to Stand for Long
- ☐ Cognitive Impairment
- ☐ Limited Range of Motion
- ☐ Uses Ambulation Device
- ☐ Paralysis
- ☐ Numbness
- ☐ General Weakness
- ☐ Other:

Section IV. Special Diet

Instructions/Notes/Comments:

Individual Name (Last, First, Middle Initial)	Date of Birth

Section V. Medications and Treatments

To provide better emergency care, list all known medications taken; not only those prescribed by this office, such as Prescribed/PRN/OTC.

Medications							
				Location of Medication Administration			
Medication	Dosage	Route	Frequency	Home	DAHS	Initial	Date
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
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				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		
				☐	☐ Self-Admin ☐ with Supervision ☐ Licensed Nurse		

Therapies or treatments performed at DAHS, including monitoring tasks, specific interventions or procedures.		
Ordered Treatments/Monitoring/Intervention	Frequency	Notes/Comments

\+ −

Section VI. Physician's Certification

I certify this individual has a chronic medical diagnosis other than an intellectual and developmental disability or mental health condition and a functional limitation, and hereby order the above care, monitoring or intervention by a licensed nurse to be performed at the DAHS facility.

I also certify that I am not a significant owner, partner or member of the service provider requesting this order for DAHS.

Signature – Physician	Today's Date	Date of Verbal Order (if app.)	End Date (if order is time limited)

Physician's Name (Type or Print)	MD	DO	License No./NPI	State	Military or VA
	☐	☐			☐ Yes ☐ No
Physician's Address (Street, City, State, and ZIP Code)				Area Code and Telephone No.	

Print Form   Reset Form

TEXAS Department of Aging and Disability Services

Form 3050
October 2016-E

Day Activity and Health Services (DAHS)

Health Assessment/Individual Service Plan

Section I – Identification and Background Information

Individual Name – (Last, First, Middle Initial)				Date of Birth
Individual's Number	**Current Date of Eligibility**	**Sex** ☐ Male ☐ Female	**Lives Alone** ☐ Yes ☐ No	**Reason for Assessment** ☐ Initial ☐ Change ☐ Ongoing
DAHS Facility Name		**DAHS Nurse**		**DAHS Area Code and Telephone No.**
DAHS Facility Address (Street, City, State and ZIP Code)				
D.A.H.S. Facility Address. Street, City, State and ZIP Code.				

Section II – Assessment of Functional/Physical Status

Indicate Problems/Conditions/Symptoms experienced within the last 30 days. Check all that are present. Enter a comment as needed for boxes checked (i.e., frequency, location, etc.). Additional space for comments is available at the end of Section II.

A. Alteration in Nutrition/Metabolism

☐ Choking, risk of aspiration	☐ Low body weight	☐ Inadequate fluid intake
☐ Inadequate nutritional intake	☒ Upset stomach/indigestion	☐ Intake exceeds body's needs
☒ Blood sugar fluctuations or abnormalities	☐ Chewing Problem	☐ Swallowing problem
☐ Uses dentures	☐ Some or all natural teeth lost – does not have/use or partial plates	
☐ Other/Specify):		☐ N/A

B. Alteration in Elimination

☒ Constipation	☐ Diarrhea	☐ Bladder incontinence program
☐ Bladder incontinence	☐ Bowel incontinence	☐ Bowel incontinence program
☐ Other/Specify):		☐ N/A

C. Alteration in Cardiac/Respiratory Status

☐ Chest Pain	☒ Cyanosis	☒ Oxygen use	☐ Blood Pressure fluctuations/abnormalities
☐ Wheezing	☐ Shortness of breath	☐ Peripheral circulation issues (including edema)	
☐ Other/Specify):			☐ N/A

D. Alteration in Skin

☐ Pressure ulcer	☐ Stasis ulcer	☐ Lesion other than pressure/status ulcer, including feet
☒ Surgical Wound	☒ Risk of skin breakdown	☐ Swelling
☐ Fragile skin	☐ Rash	
☐ Skin desensitized to pain or pressure	☒ Abrasions, bruises	
☐ Other/Specify):		☐ N/A

E. Alteration/Deficit in Body Control

☐ Unsteady gait	☒ Amputation	☐ Balanced – partial/total loss of ability to balance while standing	
☐ Quadriplegia	☐ Hemiplegia/hemiparesis	☐ Lack of hand dexterity (ie: problem using utensils)	
☐ Uses ambulation device	☐ Paraplegia	☐ Arm/Leg/trunk – Part or total loss of Voluntary movement	
☐ Other/Specify):		☐ Contractures	☐ N/A

F. Alteration in Neurological Status

☒ Seizures	☐ Tremors	☒ Generalized weakness	☐ Dizziness vertigo	☐ Not oriented X3
☐ Limitations in cognition	☐ Other:			☐ N/A

Individual Name – (Last, First, Middle Initial)	Date of Birth	Individual's Number

G. Altered Sensory.Perceptual Awareness

- ☐ Pain
- ☐ Vision deficit – minimally impaired
- ☐ Vision deficit – highly impaired
- ☐ Other/Specify): _____
- ☐ Wears glasses or contacts
- ☐ Hearing deficit – minimally impaired
- ☐ Hearing deficit – highly impaired
- ☐ Wears hearing aid
- ☐ N/A

H. Communications Deficits

- ☐ Difficulty making self understood, Limited to
- ☐ Making concrete requests, Difficulty finding
- ☐ Wording/finishing thoughts
- ☐ Other: _____
- ☐ Difficulty understanding
- ☐ Rarely/never understands
- ☐ N/A
- ☐ May miss intent or message
- ☐ Only sometimes understands

I. Behavior Challenges

- ☐ Wandering
- ☐ Motor agitation
- ☐ Failure to eat or take medication
- ☐ Socially inappropriate or disruptive behaviors
- ☐ Other: _____
- ☐ N/A

J. Vital Signs/Height/Weight/Blood Sugar

Blood Pressure	Pulse	Respiration	Temp. (optional)	Height	Weight	Blood Sugar (optional)

Additional Comments:

Section III – Therapies and Treatments

Check therapies the individual is **currently** receiving from **any** source.

- ☐ Speech – language pathology, audiology services
- ☐ Occupational Therapy
- ☐ Chemotherapy
- ☐ Other: _____
- ☐ Physical Therapy
- ☐ Respiratory Therapy
- ☐ Dialysis
- ☐ Psychology Therapy (licensed professional)
- ☐ Radiation

Section IV – Plan of Care: Personal Care at the DAHS Facility

Check the appropriate boxes if assistance with the task will be provided at the DAHS facility.

A. Transfer ☐ **No Assistance Needed**

Assistance Needed	Schedule/Frequency	Comments
☐ Setup Required		
☐ One-Person Physical Assistance		
☐ Two-Person Physical Assistance		

B. Ambulation ☐ **No Assistance Needed**

Individual Uses the Following Aids: ☐ Cane ☐ Walker ☐ Wheelchair-Self ☐ Wheelchair-Assisted

Assistance Needed	Schedule/Frequency	Comments
☐ Setup Required		
☐ One-Person Physical Assistance		
☐ Two-Person Physical Assistance		

Individual Name – (Last, First, Middle Initial)	Date of Birth	Individual's Number

C. Eating ☐ No Assistance Needed

Individual Uses the Following Aids: ☐ Feeding Tube ☐ Syringe (Oral Feeding) ☐ Plate Guard, Stabilized Built-Up Utensil, etc.
☐ Other:

Assistance Needed	Schedule/Frequency	Comments
☐ Setup Required		
☒ One-Person Physical Assistance		
☐ Two-Person Physical Assistance		

D. Toileting ☐ No Assistance Needed

Individual Uses the Following Aids: ☐ External (condom) Catheter ☒ Indwelling Catheter ☐ Intermittent Catheter ☐ Pads, Diapers

Toileting Program: ☒ Yes ☐ No ☐ Ostomy ☐ Enema, Irrigation

Assistance Needed	Schedule/Frequency	Comments
☐ Setup Required Option 1 of 3, setup required		
☒ One-Person Physical Assistance		
☐ Two-Person Physical Assistance		

E. Bathing ☐ No Assistance Needed

Individual Uses the Following Aids: ☒ Shower Chair ☒ Transfer Bench ☒ Handheld Shower Wand ☒ Sponge Bath

Assistance Needed	Schedule/Frequency	Comments
☐ Setup Required		
☒ One-Person Physical Assistance		
☐ Two-Person Physical Assistance		

F. Dressing and Grooming ☒ No Assistance Needed

Individual Uses the Following Aids: ☐ Shaving ☐ Hair Care ☐ Brushing Teeth ☐ Nail Care ☐ Dressing

Assistance Needed	Schedule/Frequency	Comments
☐ Setup Required		
☐ One-Person Physical Assistance		
☐ Two-Person Physical Assistance		

Option 3 of 3, Two-Person Physical Assistance

G. Assistance with Self-Administer Medication While Attending DAHS ☐ No Assistance Needed

Individual Needs Assistance with Self-administering Medication

Medications	Schedule/Frequency	Comments

+ −

Individual Name – (Last, First, Middle Initial)	te of Birth	Individual's Number

Section V – Therapeutically Benefit

This individual will benefit therapeutically from DAHS by:

Additional Information/Notes:

Section VI – Participation in Assessment

Individual	Family	Significant Other	Responsible Party
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Comments:

Signature – Individual or Responsible Person

Date

I certify this individual has a chronic medical condition and will benefit therapeutically from DAHS.

Signature – Nurse Completing Form

Date Assessment Completed

Printed Name – Nurse Completing Form

Area Code and Telephone Number

Sunrise
Adult Activity & Health Center
We Are Your Family Outside the Home

9525 Wilcrest Drive Houston, TX 770
Tel: 832-379-3795 | Direct: 832-794-21
Fax: 281-858-20
Email: sunriseactivity@yahoo.co
www.sunriseactivity.co

Notice of Acknowledgement Advance Directive

Patient Name _____ Date of Birth _____

An Advance Directive is a legal document allowing a person to give directions about future medical care or to designate another person(s) to make medical decision if he or she should lose the decision-making capacity. Advance Directives are the following written instruments: The Living Will and The Durable Power of Attorney for Health Care. The instruments may be revoked and a notation of the date and time must be made to the patient's medical record.

Do you have a Directive to Physicians (Living Will)? Yes _____ No _____

Do you have a Durable Power of Attorney for Health Care? Yes _____ No _____

Is it up-to-date? Yes _____ No _____

Where is a copy being kept? _____
_____

Principal Agent name: _____ Tel: _____
Address _____
_____

Alternate Agent name: _____ Tel: _____
Address _____
_____

_____ _____
Signature of Patient or Representative Date