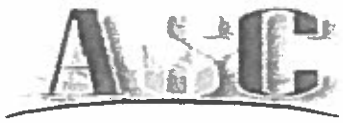

Dear Family Member,

Thank you for your interest in Alzheimer's Services Center. We offer the following services: daycare, respite, and/or outreach program.

We have enclosed a brochure describing our services. Our core foundation is built on the commitment to provide quality services to our clients. We provide an ongoing commitment to giving our clients the highest quality of care and support to their caregivers. We are available to answer any additional questions you may have about our program. You may contact us at the above telephone number during normal business hours (7:30 am to 4:30 pm) Monday through Friday.

We have also enclosed forms that would be helpful for us to provide relevant information. Please follow these procedures below:

- Complete the Client Information Form
- Have your loved one's Primary Care Physician complete the Medical Examination Form
- Current T. B. test results or a chest x-ray report must be included
- Affidavit verifying status of citizenship which will need to be notarized

Once you have completed and returned these forms back to us, our intake nurse will call you to set up an appointment time for an admission evaluation. Please plan for a two (2) hour process. Our intake nurse will complete an evaluation along with our Social Worker to determine if our Program is appropriate for your loved one. You will also need to bring insurance cards and all medications in their bottles.

You may contact our Outreach personnel to schedule an appointment regarding admission to the Center. We look forward to hearing from you soon.

With kindest regards,

Melissa Myers-Bristol, MPA
Executive Director

Enclosures

ALZHEIMER'S SERVICES CENTER
7251 MT. ZION CIRCLE
MORROW, GA 30620-3309
770 603-4090-Office – 770 603-4092-Fax
info@asc-ga.org

CLIENT INFORMATION & EMERGENCY MEDICAL FORM

Alzheimer's Service Center
7251 Mount Zion Circle Morrow, GA 30260
www.asc-ga.org

Participant's Name:_____ D.O.B._____ Age_____

Address:_____ M ☐ F ☐

City:_____ County:_____ Zip:_____

Caregiver's Name:_____ Relationship:_____

Caregiver's D.O.B. _____ SS#_____

Address:_____

City:_____ County:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____ E-Mail_____

Person to contact if caregiver is unavailable:

Name:_____ Relationship:_____

Address:_____

City:_____ County:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

In the event of my unavailability, I authorize the official staff of the Alzheimer's Services Center to act for me in giving consent for medical treatment if necessary for:_____

Medicare Number:_____ Medicaid Number:_____ SS#_____

Other:_____

Primary Physician:_____ Office Phone:_____

Hospital:_____ Phone:_____

Ambulance Service:_____ Phone:_____

Allergies:_____
Diagnosis of Alzheimer's Disease ☐ Yes ☐ No Date of DX:_____

Pertinent Medical History:_____
Special Needs:_____
Advance Directive Information:_____

In case of Medical Emergency, I agree for 911to be notified for possible transport to nearest hospital
If not, who should be contacted?_____ Current Medications:_____

_____(I agree to assume responsibility for **all expenses involved in receiving prompt medical care.)**

How did you hear about our Center? _____

Signature of Caregiver/Guardian:_____ **Date:**_____

Alzheimer's Service Center
7251 Mount Zion Circle Morrow, GA 30260
www.asc-ga.org

Affidavit Verifying Status Of Benefit Applicant

Pursuant to the Georgia Security and Immigration Compliance Act {O.C.G.A. 50-36-1} Effective July 1, 2007, every agency in _____County providing public benefits through any state or federal program is responsible for determining the immigration status of citizen applicants for said benefits.

By executing this affidavit under oath, as an applicant for benefits, I am stating the following with respect to my application for benefits from _____:

_____ I am a United States citizen or legal permanent resident 18 years of age or older:

OR

_____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older and lawfully present in the United States.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of Code Section 16-10-20 of the Official Code of Georgia.

_____ _____
Signature of Applicant Date

_____
Printed Name

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE

_____DAY OF_____,20_____

_____
Notary Public
My Commission Expires:

_____

Alzheimer's Services Center

7251 Mount Zion Circle
Morrow, GA 30260
Phone: 770-603-4090 or Fax: 770-603-4092

MEDICAL EXAMINATION

(To Be Completed By Physician)

Date: ____ /____ /_____

Patient's Name: _____D.O.B. ____ /____ /_____

Diagnosis of Alzheimer's disease: Yes ☐ No ☐ Date of Diagnosis: ____ /____ /_____

Other Diagnosis, Medical Problems, or Impairments

_____

_____

Vital Signs BP: _____ Heart Rate_____ Respiration: _____

Has patient been given mini mental status test? _____ Total Score: _____

Date of Last Examination_____

Standing Orders

The following orders once signed by the physician are effective for one (1) year and must be updated yearly.

1. Tylenol 325mg. 1 0r 2 tablets every 4 hours as needed for pain or fever
   Physician initial

Yes	No

2. May check blood glucose with finger stick testing unit as needed for sign/symptoms of hyper/hypo-glycaemia.
   Physician initial

Yes	No

3. Minor wound care as needed-cleanse with peroxide, apply triple antibodies and dressing
   Physician initial

Yes	No

4. Tums 1 or 2 every 4 hours as needed for indigestion/heartburn
   Physician initial

Yes	No

5. Maalox 30cc every 4 hours as needed for stomach upset

Yes	No

Alzheimer's Services Center

7251 Mount Zion Circle
Morrow, GA 30260
Phone: 770-603-4090 or Fax: 770-603-4092

MEDICAL EXAMINATION

(To Be Completed By Physician)

Physician initial

TB Test Results or Current Chest X-Ray Date (Please Note: Certification of a Negative TB Test Chest X-Ray within the past 3 months is required) _____

Physicians Name_____

Signature_____ Date: ____ /____ /_____

Address: _____

City: _____ Zip_____

Telephone: _____

Healthcare Facility Regulation Division

PHYSICIAN'S MEDICAL EVALUATION FOR ASSISTED LIVING

NAME OF PATIENT			DOB	HEIGHT
PRESENT ADDRESS				WEIGHT
CITY	STATE	ZIP	TELEPHONE	

REASON FOR EVALUATION:
☐ Pre-Admission ☐ Annual ☐ Possible change in patient's condition ☐ Other (Describe)_____

1. Current Diagnosis(es)

2. Physical Limitations

3. Mental Health Limitations

4. Treatment/Therapies (Describe medical services or nursing care or treatment needed.)

5. Supportive Services Needed

6. Allergies

7. DIET INSTRUCTION: ☐ Regular ☐ No added table salt ☐ No concentrated sweets
☐ Other_____

8. STATUS OF THE FOLLOWING:

AMBULATING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help
☐ Bedridden

BATHING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help

DRESSING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help

EATING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Tube feeding

GROOMING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help

SKIN INTEGRITY
☐ No pressure sores
☐ Stage one
☐ Stage two
☐ Stage three
☐ Stage four
Location _____

TOILETING
☐ Independent
☐ Needs supervision
☐ Hygiene assistance
☐ Adult briefs
☐ Catheter care assistance
☐ Ostomy

TRANSFERRING
☐ Independent
☐ Needs supervision
☐ Needs assistance
☐ Needs total help

RESTRAINTS
☐ Requires no restraints ☐ Requires chemical restraints Type_____ ☐ Requires physical restraints Type_____

9. CIRCLE THE APPROPRIATE ANSWER IN EACH STATEMENT BELOW.

a. The individual HAS HAS NOT received screening for TB and the individual HAS DOES NOT HAVE signs and/or symptoms of infectious diseases which are likely to be transmitted to other residents or staff.
TB SCREENING INFORMATION: Date:_____ Results:_____

b. The individual's behavior DOES DOES NOT pose a danger to self or others. If DOES, please explain. If medications are necessary to control behavior, please explain._____

c. The individual DOES DOES NOT require assistance from staff during the night. If assistance is required, please explain.

_____

_____

d. The individual DOES DOES NOT require 24 hour nursing supervision.

e. The individual DOES DOES NOT require placement in a specialized memory care unit (unit with controlled access/egress designed to serve residents who are at risk of engaging in unsafe wandering activities or other unsafe behaviors).

10. MEDICATIONS: List all medications including over the counter medications, herbal remedies, topical medications, vitamins, etc. Any PRN medications must include instructions, i.e. parameters for use.

MEDICATION	DOSAGE	DIRECTIONS FOR USE	ROUTE	NEEDS HELP WITH ADMINISTRATION YES	NO

MEDICAL CERTIFICATION SIGNATURE REQUIRED:

Assisted living facilities/personal care homes ARE NOT permitted under the law to provide medical, skilled nursing or psychiatric care. In your professional opinion, can this patient's needs be safely met in an assisted living facility/personal care home? YES: _____ NO: _____

COMMENTS:

SIGNATURE OF PHYSICIAN, PA OR NP:	DATE:
PRINTED NAME OF PHYSICIAN, PA OR NP	GEORGIA LICENSE #
ADDRESS OF PHYSICIAN, PA OR NP	
CITY / STATE / ZIP CODE	

PLEASE RETURN COMPLETED FORM TO:

CONTACT PERSON	FACILITY NAME
ADDRESS	PHONE:
CITY / STATE / ZIP CODE	