Parker Jewish Institute
FOR HEALTH CARE AND REHABILITATION

PARKER ON MADISON
SOCIAL ADULT DAY CARE

CAREGIVER APPLICATION

Participant's Name: _____ **Date of Birth:** _____

Address: _____

City, State, Zip: _____ **Telephone #:** _____

Religion: _____

Caregiver Name: _____ **Telephone #:** _____

Relationship to Participant: _____ **Email Address:** _____

Address, if different: _____

Physician: (Internist, Family MD)

_____ **Telephone #:** _____

Address: _____

City, State, Zip: _____ **Hosp. Affiliation:** _____

Specialist: (Cardiologist, Neurologist)

_____ **Telephone #:** _____

Health History (list illnesses, if any)**:**

_____

_____

_____

Parker Jewish Institute
FOR HEALTH CARE AND REHABILITATION

PARKER ON MADISON
SOCIAL ADULT DAY CARE

Medications (list drug, dosage, frequency and purpose for all medication): ☐ **None**

_____

_____

_____

Does Participant Require?

☐ Cane ☐ Walker ☐ Wheelchair ☐ Glasses

☐ Hearing Aid ☐ Dentures ☐ Other: _____

Is Participant Continent? Bowel ☐ Yes ☐ No ☐ Sometimes
Bladder ☐ Yes ☐ No ☐ Sometimes

Does Participant Wander? ☐ Yes ☐ No

Does Participant Have a Swallowing Problem?: ☐ Yes ☐ No

Special Diet?: ☐ No ☐ Yes (if so, please specify)

_____

Food Allergies? _____

Drug Allergies? _____

Has the Participant Been Enrolled in Any Other Day Care Program?: ☐ Yes ☐ No

If yes, please specify: _____

Is the Participant on Medicaid?

☐ Yes, Number_____ ☐ No

Parker Jewish Institute
FOR HEALTH CARE AND REHABILITATION

PARKER ON MADISON
SOCIAL ADULT DAY CARE

EMERGENCY CONTACTS (in priority order – must list at least 2 contacts)

1) PRIMARY EMERGENCY CONTACT

Name:

Relationship:

Address:

Home Phone:

Work Phone:

Cell Phone:

2) EMERGENCY CONTACT #2

Name:

Relationship:

Address:

Home Phone:

Work Phone:

Cell Phone:

3) EMERGENCY CONTACT #3

Name:

Relationship:

Address:

Home Phone:

Work Phone:

Cell Phone:

Parker Jewish Institute
FOR HEALTH CARE AND REHABILITATION

PARKER ON MADISON
SOCIAL ADULT DAY CARE

I hereby certify that this application is complete and accurate to the best of my knowledge:

Caregiver's Name (printed): _____

Caregiver's Signature: _____ **Date:** _____

If returning application by email, please return to:

Trishanne Denhart – **tdenhart@parkerinstitute.org**

Rafeena Rahmaan-Ally – rrahmaan-ally@parkerinstitute.org

If returning application by mail, please return in the enclosed postage paid, self-addressed envelope to:

Parker on Madison Social Adult Day Care
Attn: Applications
92 Madison Avenue
Hempstead, NY 11550
Tel. No.: (516) 586-1623

Parker Jewish Institute
FOR HEALTH CARE AND REHABILITATION

PARKER ON MADISON
SOCIAL ADULT DAY CARE

APPLICATION TO DAY CARE PROGRAM

Name: _____

Please answer the following questions about your relative: (check all that apply)

WALKING ABILITY:

- ☐ no difficulty (steady on feet)
- ☐ unsteady on feet
- ☐ sits in mid air
- ☐ needs assistance to sit and stand

EATING:

- ☐ independent
- ☐ needs verbal cues to swallow
- ☐ needs motivation to eat
- ☐ needs to be fed

ABLE TO READ?

☐yes ☐no ☐unsure

ABLE TO TELL TIME?

☐yes ☐no ☐unsure

ABLE TO WRITE?

☐yes ☐no ☐unsure

BATHROOM USE:

- ☐ can make needs known
- ☐ needs verbal cueing only
- ☐ needs assistance (e.g., clothing, positioning)
- ☐ needs assistance with paper, soap, flushing
- ☐ needs privacy
- ☐ requires complete assistance

SPEAKING ABILITY:

- ☐ does not verbalize
- ☐ initiates irrelevant conversations
- ☐ uses one or two word responses
- ☐ able to form complete sentences
- ☐ able to express self
- ☐ unable to express an idea
- ☐ has difficulty finding words

Parker Jewish Institute
FOR HEALTH CARE AND REHABILITATION

PARKER ON MADISON
SOCIAL ADULT DAY CARE

ABILITY TO FOLLOW DIRECTIONS:

- ☐ follows three-step instructions
- ☐ follows two-step instructions
- ☐ follows one-step instructions
- ☐ needs hand over hand assistance

COMPLETES TASKS:

- ☐ able to complete tasks independently
- ☐ needs both verbal prompting and demonstration
- ☐ needs consistent verbal prompting
- ☐ fails to participate
- ☐ needs physical assistance

SOCIAL SKILLS:

- ☐ is polite
- ☐ is critical of others
- ☐ responds to inappropriate behavior of others
- ☐ displays inappropriate behavior towards others

MEMORY:

- ☐ recognizes family members
- ☐ minor short term memory deficit

  (describe) _____
- ☐ major short term memory deficit

  (describe) _____
- ☐ long term memory intact
- ☐ reminisces

Parker Jewish Institute
FOR HEALTH CARE AND REHABILITATION

PARKER ON MADISON
SOCIAL ADULT DAY CARE

WHY DO YOU WISH YOUR RELATIVE TO BE ENROLLED IN THIS PROGRAM?

_____

_____

_____

_____

_____

_____