Important – Please read all Information below

Welcome to Mountain Explorers!

Mountain Explorers is a day program for adults who have a mild impairment and are interested in a structured program for social opportunities, mental stimulation, exercise and enrichment. As soon as we receive the completed paperwork, ***along with the $40 enrollment fee***, we will schedule your family member for their orientation day. If the first day is successful, as most of them are, we will enroll your family member at the end of that period.

A Few Reminders…

* The program meets Mondays, Wednesday, and Fridays. A person may enroll for one, two or three days.

* The hours of the program are from 10:00 a.m. to 3:00 p.m. "it is ***imperative*** that members arrive and depart as close to these times as possible to avoid early/late charges and to allow for timely departures for outings."

* Billing is done on a monthly basis for all days ***enrolled*** the previous month.

Below is a checklist to help guide you through completion of the application packet:

- ☐ Complete Application for Enrollment
- ☐ Complete Social/Lifestyle History
- ☐ Complete Health Form
- ☐ Sign Consent and Authorization Form ***and have witnessed*** if appropriate.
- ☐ Return packet to MountainCare Adult Day Services along with $40 enrollment fee.
- ☐ Bring **ORIGINAL** DNR / MOST Form if applicable.
- ☐ Bring Insurance cards to be copied.
- ☐ Bring HCPOA or POA if applicable.

2/1/19

Mountain Explorers

APPLICATION FOR ENROLLMENT

For office use only:

Participant I.D. #________ Non-refundable Enrollment Fee $40.00_______(check when received)

Re-enrollment Fee: $20.00______(check when received)

Circle all that apply: *Mountain Explorers (Buncombe only) DC/DH - Buncombe / Henderson / Transylvania*

Applicant's full name: ________________________________ Preferred Name: ______________

Birth date:_________________Male________Female______Marital Status: ___________________

Address:____

Telephone:___________________________Social Security No: ______________________________

Caregiver E-mail Address:____

Reason for interest in coming to this program: ____

____

Has Applicant had previous experience in a Day Program? Yes No

Living with whom:______________________Relationship_______________________________

It is ***VERY*** important that we are able to contact someone during the day if necessary. Please list at least two people to contact, and the number(s) at which they can be reached throughout the day. The **first person** should be the **primary caregiver** (closest relative or person he/she resides with).

1) Name:____Relationship:_____________

Address____

Home phone:________________Business phone:_______________Cell/Beeper#_________________

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2) Name:____Relationship:_____________________

Address____

Home phone:________________Business phone:______________Cell/Beeper # _______________

Do you plan to provide your own transportation? Yes No *(if no, a Transportation Needs Assessment will be completed)*

Anticipated days of enrollment: Mon. Tues. Wed. Thurs. Fri. Sat. *(Circle days that apply)*

Approximate time of arrival and departure daily: Arrival________________Departure _____________

Signed____Date______________________________

Contact information for additional family members/friends may be listed on the reverse side of this form.

Please list below any additional family members/friends that may be contacted if neither of the persons listed on the front can be reached.

Name:____Relationship:____________________

Address____

Home phone:_________________Business phone:_______________Cell/Beeper # ________________

Name:____Relationship:____________________

Address____

Home phone:_________________Business phone:_______________Cell/Beeper # ________________

Revised 2/1/19

DATE________

MOUNTAINCARE ADULT DAY SERVICES

Buncombe County Center / Henderson County Center / Transylvania County Center

SOCIAL / LIFESTYLE HISTORY

Name of Participant____

Past Occupation (s): ____

Does Participant have a military past? ***YES / NO*** *(circle)* **Branch**:______________**Rank**: ___________

Special experience/recognition: ____

Highest level of Education/Diploma: ____

Club or Civic Organization Involvement: ____

____

Religious preference / involvement: ____

Primary Language:______________________**Other Languages Spoken:** _____________________

Race: *(circle)* African American Asian Caucasian Native American Hispanic Other Unknown

Most important factor(s) in life (such as occupation, religion, family, personal interests, hobbies, etc.):

____

____

Name and relation of anyone that the participant may talk frequently about:

Name	***Relationship***	***Name***	***Relationship***

Pets: Does or did your loved one have a pet that was important to them? **YES / NO**

If Yes: What kind of pet(s)?_________________________Pet's Name(s) _________________________

Does he/she enjoy being around small children? ***YES / NO*** (please circle)

Sociability: He/she enjoys **large** groups / small groups **/** **both** / **neither** (please circle)

Comments: ____

____

Past and/or present hobbies, sports, areas of interest: (please check all that apply)

Cooking		Gardening		Exercise		Movies		Crocheting	
Sewing		Woodworking		Animals		Flower Arranging		Travel	
Quilting		Reading		Music		Card Games		Table Games	
Bible Study		Singing		News		Bingo		Sports	
Arts		Dancing		Crafts		Puzzles		Board games	

Habits and patterns: Does your loved one have any unique patterns or habits that would be helpful for us to know about? (For example, they always take a walk after lunch, they are used to having "tea" in the afternoon, or they like to read the paper in the morning, etc.):

Eating/Drinking habits:
Preferred/favorite beverage?

Preferred/favorite foods?

Foods strongly disliked?

If coming for a full day, will he/she eat breakfast at home? ***YES / NO (***please circle)

Resting Habits: Does he/she normally take a nap during the day? ***YES / NO*** (please circle)

Current Tobacco Use: (please circle) None Cigarettes Cigars Pipe Snuff/Chewing Tobacco

As we care for your loved one, what are the most important things we should know or do to make his/her time in the program successful?

Additional Information/Comments:

IF YOU HAVE ANY PICTURES THAT YOUR LOVED ONE MIGHT ENJOY SHARING, PLEASE BRING COPIES (NOT THE ORIGINALS) – IT HELPS STAFF GET TO KNOW THEM.

THIS FORM WAS COMPLETED BY: ____________________________

THANK YOU FOR TAKING THE TIME TOHELP US GET TO KNOW YOUR FAMILY MEMBER BETTER

ADULT DAY SERVICES HEALTH FORM
MOUNTAIN EXPLORERS PROGRAM

MEMBER NAME_____________________________________DATE OF BIRTH________________

History of Disease/ Chronic Condition	*Current Condition*	*Past History*	*If MARKED, please provide further detail below*
• Anemia	______	______	____
• Arthritis	______	______	____
• Cardiac	______	______	____
• Cancer	______	______	____
• Diabetes	______	______	____
• Effects of Stroke	______	______	____
• Epilepsy/Seizures	______	______	____
• Gastro-Intestinal	______	______	____
• HIV	______	______	____
• Hearing	______	______	____
• High Blood Pressure	______	______	____
• Respiratory/Pulmonary	______	______	____
• Tuberculosis	______	______	____
• Urinary Tract	______	______	____
• Vision	______	______	____
• Dementia	______	______	____

Does this person have any psychiatric or behavioral concerns? If so, please comment on nature, severity, and treatment needs: ____

Please describe any other disease or condition not mentioned above:
____
____

Any special dietary requirements? Yes_____ No ______ If yes please provide details
____
____

Allergies or reactions: ☐ **No known allergies** ☐ Insect/Bee sting ☐ Food ☐ Medication ☐ Perfumes/Lotions

☐Animals ☐Latex *If any are checked, please specify:* ____

If member has a severe allergy to bee stings, does he/she have an Epi Pen? Yes ____ No ____
If severely allergic, it is the responsibility of the caregiver to provide the program with a non-expired Epi Pen to prevent an adverse reaction to a sting. If an Epi Pen is not available in the event of a severe allergic reaction, the center's staff will contact Emergency Responders.

Does member have a current DNR (Do Not Resuscitate) order or M.O.S.T. form? Y____ N____

If yes, please provide 1 *ORIGINAL FORM* for the program to have on file in case of emergency

MountainCare

CARING FOR OUR WNC NEIGHBORS

Buncombe County Center ***Henderson County Center*** ***Transylvania County Center*** **(please circle)**

CONSENT AND AUTHORIZATION FORM

PARTICIPANT NAME: ____

In consideration of services and/or health care treatment to be provided, the undersigned acknowledges, authorizes and agrees to the following:

1. CONSENT FOR CARE AND TREATMENT.

I voluntarily consent to admission to MountainCare, Inc. ("MountainCare") for adult day services.

Physician-Directed Services: I hereby authorize and direct MountainCare's medical and other clinical staff to perform or administer treatment, medications, procedures, examinations, and/or injections under the direction of my attending physician. I understand I have the right to be informed by my physician(s) of the nature and purpose of any proposed treatment regimen or procedure and any available alternative methods of treatment, together with an explanation of the associated risks/precautions. This form is not a substitute for such explanations, which my physician(s) are responsible to provide according to recognized standards of medical care.

Other Services: I hereby authorize and direct MountainCare's medical and other staff to provide services that are requested by me or my Responsible Party and that in their best judgment are necessary and in my best interest.

2. CONSENT FOR RELEASE OF MEDICAL INFORMATION/TRANSMISSION OF INFORMATION.

I authorize MountainCare to furnish medical information (except psychotherapy notes), including any information relating to identity, diagnosis, prognosis or treatment of any medical condition, including psychiatric disorders and alcohol or drug abuse, results of HIV testing, diagnosis of Acquired Immune Deficiency Syndrome (AIDS) and/or other communicable diseases, relating to this episode of treatment for the purposes of treatment, payment and health care operations to the following persons, facilities or entities:

A. other health care providers for treatment purposes, continuity of care and follow-up; to my referring physician, attending physician, primary care physicians, consulting physicians, and hospital based physicians, as well as, to any licensed physician, health care agency, other clinician, or medical or nursing facility to which I am referred or transferred for further medical care. Information may be released to other agencies such as medical equipment and infusion therapy companies for provision of my care. I understand that this information will only be provided when required to assure appropriate coordination of medical services on my behalf;

B. any insurance company, managed care company, Medicare, Medicaid, workers' compensation or other payor that I identify as providing benefits to me or to MountainCare, any governmental or charitable agencies or their agents, and any professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my hospital and medical care expenses;

C. groups or their agents identified in the Assignment of Insurance Benefits form;

D. any person or external review agency involved in reviewing, authorizing, or processing my eligibility for health insurance coverage, payment of benefits or billing compliance for the payers that I identify;

E. emergency transport services that transport me to or from MountainCare;

F. regulatory, accrediting, and quality review persons or agencies such as Medicaid, and NC Department of Health and Human Services, who monitor MountainCare's compliance with regulatory requirements and assuring quality outcomes for participant care.

G. family members or persons that I or my representative identify as involved in my care. This consent does not authorize the release of a copy of my medical records to family members or other persons involved in my care;

H. persons at my home or other designated location or number that I provide (including telephone, e-mail or mail for follow-up calls or messages to me or my representative) concerning appointment reminders or

request for a return call; and

I understand that MountainCare's operations may include medical, technical, or clinical students and/or trainees which may assist licensed staff in the provision of care, and that these individuals may be part of my care team with the approval of, and under the guidance and supervision of MountainCare staff.

I understand that MountainCare will take reasonable precaution to protect the confidentiality of my health care information. I also understand that my name, location and a one word description of my general condition (fair, stable, good, serious, etc.) may be released, if requested, to callers and/or visitors.

3. AUTHORIZATION FOR TAKING PICTURES, AUDIO AND/OR VISUAL RECORDINGS.

I authorize MountainCare, its agents, employees, and other parties under contract with MountainCare to take, develop, print, and copy photographs/video recordings of myself or parts of my body, and/or audio recordings regarding my treatment FOR THE PURPOSE OF MEDICAL DOCUMENTATION. I understand that such photographs/audio/video recordings may be used to document and support the clinical course of my care, third party reimbursement, or staff education. I also understand and acknowledge that any photographs/audio/video recordings taken pursuant to the agreement shall be the property of MountainCare and do hereby release, relinquish, and waive any right, title, or interest which I might have in photographs/audio/video recordings hereby authorized. This consent for such media shall be continuing at all times during this episode of care unless revoked in writing by myself or authorized representative. Finally, such media may be made and placed in my medical record.

4. ADVANCE DIRECTIVES (*for persons 18 years of age or older*).

I have received a copy of "Medical Care Decisions and Advance Directives: What You Should Know." I understand that MountainCare maintains policies and procedures to protect my right to make health care decisions. This includes the right to review my plan of care, accept or refuse treatment and the right to formulate advance directives. I understand that some medical services or procedures may not be provided through Hospice services, including advanced life support. I acknowledge my right to request and receive copies of advance directive policies and procedures at any time.

5. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

I have reviewed or been given the opportunity to review MountainCare's Notice of Privacy Practices that describes how my health information is used and shared. I understand that MountainCare has the right to change this notice at any time. If desired, I may obtain a current copy of the Notice by contacting MountainCare's Intake Office for the services that I am receiving.

As the undersigned, I certify that I have read the foregoing and that I have received a copy of the foregoing. I have been encouraged to ask questions if I do not understand. I voluntarily sign this form and understand that I may revoke consent at any time by notifying MountainCare in writing, except to the extent action has already been taken based upon this consent, including the disclosure of information to third party payors to seek payment for the care and treatment provided to me. Unless revoked by me, this consent and authorization remains in effect for two (2) years from the date written below. I certify that I am the participant, or am duly authorized by the participant as the participant's general agent or representative (Responsible Party) to execute the foregoing and accept its terms.

________________________________ Dated this ______ day of ____________________, 20______
(Participants Signature)

________________________________ ________________________________
(Signature of Participant's Agent or Responsible Party) (Witness)

Responsible Party. I am acting on behalf of the participant and authorize the provision of services and release of medical information as directed above. The participant has granted me the authority and is giving me permission to act on their behalf. My relationship to the participant is ________
acting on behalf of the participant because ________________________________