**Section 390.APPENDIX B Forms for Day Care in Long-Term Care Facilities**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| APPENDIX B | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Form A | | | | | |  | | | | | | | | | | | | | | | | | Sample | | | | |
| Forms for Day Care in Long-Term Care Facilities | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| APPLICATION FOR DAY CARE | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NAME | |  | | | | | | | | | AGE | | | |  | | | | BIRTH DATE | | | | | |  | | |
| ADDRESS | | | |  | | | | | | | PHONE | | | | |  | | | | | | | | | | | |
|  | | | |  | | | | | | | SOCIAL SECURITY NUMBER | | | | | | | | | | | | |  | | | |
|  | | | | | | | | | | | MEDICARE NUMBER | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WITH WHOM DO YOU LIVE? | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RELATIONSHIP? | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | |
| PERSON TO CONTACT IN AN EMERGENCY | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | ADDRESS | | | | | |  | | | | | | | | | | | | |
|  | | | | | |  | | | PHONE | | |  | | | | | | BUSINESS PHONE | | | | | | | |  | |
|  | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | |
| PHYSICAL LIMITATIONS (please list) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | |  | | | | | | | | | | | | | | |
| 1. |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| 2. |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| 3. |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| 4. |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| SPECIAL PHYSICAL NEEDS (medications during day, special rest periods, etc. please list) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. |  | | | | | | | | | 4. |  | | | | | | | | | | | | | |  | | |
| 2. |  | | | | | | | | | 5. |  | | | | | | | | | | | | | |  | | |
| 3. |  | | | | | | | | | 6. |  | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MEDICAL PROBLEMS (circle) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | 1. | | diabetic | | | | | | | | | | 8. | | | | hearing | | | | | | | | | | |
|  | 2. | | subject to seizures | | | | | | | | | | 9. | | | | eyesight | | | | | | | | | | |
|  | 3. | | heart disease | | | | | | | | | | 10. | | | | assistance with meals | | | | | | | | | | |
|  | 4. | | dizziness | | | | | | | | | | 11. | | | | any paralysis | | | | | | | | | | |
|  | 5. | | urinary control problem | | | | | | | | | | 12. | | | | difficulty in walking | | | | | | | | | | |
|  | 6. | | bowel control problem | | | | | | | | | | 13. | | | | periodic confusion | | | | | | | | | | |
|  | 7. | | special diet | | | | | | | | | | 14. | | | | allergies (list) | | | | | | | | | | |
|  | | | | | | | | | | | | | 15. | | | | others | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ARE YOU PRESENTLY UNDER A DOCTOR'S CARE? | | | | | | | | | | | | | | | | | |  | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NAME AND ADDRESS OF PHYSICIANS | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
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|  | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
| SPECIAL INTEREST OR HOBBIES | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
| DAYS ENTERED IN PROGRAMMING | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | A.M. | | | | | | |  | | | P.M. | | | | |  | | | | | |
|  | | Monday | | | | |  | | | | | | |  | | |  | | | | |  | | | | | |
|  | | Tuesday | | | | |  | | | | | | |  | | |  | | | | |  | | | | | |
|  | | Wednesday | | | | |  | | | | | | |  | | |  | | | | |  | | | | | |
|  | | Thursday | | | | |  | | | | | | |  | | |  | | | | |  | | | | | |
|  | | Friday | | | | |  | | | | | | |  | | |  | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DO YOU HAVE TRANSPORTATION? | | | | | | | | | | |  | | | | | | | | | |  | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Form B | | | | | | | | Sample | | |
| PHYSICIAN PERMISSION FORM | | | | | | | | | | |
|  | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_has applied for admittance to the day care program at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please supply the following information and also give written permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in the activity program. | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | Physical Limitations | | | |  | | | |
|  | | | |  | | | | | | |
|  | | | Degree of activity | | | |  | | | |
|  | | | | | | |  | | | |
|  | | | | | | | | | | |
|  | | | Can day care resident be involved in activities outside of the facility (in | | | | | | | |
| the community)? | |  | | | | | | | | |
|  | | | | | | | | | | |
|  | | | Has \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_been evaluated within the last 30 days | | | | | | | |
| and found to be free of communicable and infectious disease? | | | | | | | | | | |
|  | | | |  | | | | | | |
|  | | | |  | | | | | | |
|  | | | |  | | | | | | |
|  | | | |  | | | | | | |
|  | | | Medications and/or treatments and diet needed by day care resident | | | | | | | |
| during the period of time spent in the facility. | | | | | | | | | | |
|  | | | |  | | | | | | |
|  | | | |  | | | | | | |
|  | | | |  | | | | | | |
|  | | | | | | | | | | |
|  | | | Can day care resident take own medication? | | | | | | |  |
|  | | | Allergies | | |  | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Date |  | | | | Signature of Physician | | | |  | |

(Source: Former Appendix B renumbered to Section 390.3510, new Appendix B adopted at 9 Ill. Reg. 10785, effective July 1, 1985)