THE GATHERING PLACE / ENROLLMENT FORM Completed by_____ Date___/___/____

PROFILE TGP Services: □ Adult Day □ Home Care □ Private Care

Title (Mr Mrs Ms Dr)

First Name:_____ Last Name _____

Nick Name:_____ Gender _____Male _____Female Date of Birth _____Mo _____Day _____Yr

START DATE _____/_____/_____ Name of Person You Live With:_____

Residential Address _____ City _____ State _____ Zip _____

MAILING ADDRESS

Name_____ Address _____

City _____ State _____ Zip _____ Email _____

CONTACT INFORMATION

Phone (home) _____ Phone (cell) _____

Phone (Fax) _____ Email _____

Marital Status _____ Spouse Name: _____

DPOA: □ Yes □ No POA: □ Yes □ No Copies: □ Yes □ No

CHARACTERISTICS: Religion_____ Weight _____ Height _____ ft. _____ in.

Primary Language_____

Occupation _____Job Title _____

Hobbies _____

Function Level_____

Pet Information

Cat(s) _____ Dog(s) _____ Other _____Notes: _____

HEALTHCARE INFORMATION Advanced Directive: □ Yes □ No Will: □ Yes □ No DNR: □ Yes □ No

Primary Care Physician_____ Physician phone _____

Physician email _____ Physician fax_____

Preferred Hospital _____

Home Health Agency _____ Preferred Hospice Agency _____

Specialist_____

Therapy Services_____

Diagnosis_____

Allergies _____

Medical Notes_____

_____

Pharmacy Name:_____ Phone Number:_____

Medication Information_____

_____

BILLING INFORMATION

Town _____ Zip Code _____Billing Cycle _____ Approved Hours _____

Company Name_____ Insurance Policy Number _____Authorizations required □ Yes □ No

Phone Number_____

Other Services: Homemaker / Meals on Wheels / Lifeline / Hospice / Bayada / VNH / SASH / Skilled home care

Proposed Funding/Payment Source: CFC-Hi/est / MNG / DHRS / HCRS / Grant / LTC Insurance / PR / VIP

Medicaid #_____ Medicare#_____ Other Insurance_____

Case Manager_____Phone_____Fax_____

Agency _____ILA complete _____Date_____

Email_____

RESPONSIBLE PARTIES

Primary Contact Name_____Relationship_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____

Email_____ HIPAA Disclosure Authorization __ Yes __ No

Emergency Contact Name_____Relationship_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____

Email_____ HIPAA Disclosure Authorization __ Yes __ No

BEHAVIORS

Toileting needs_____ Shower □ Yes □ No Day of Week. M T W Th F Type of assistance_____

Mobility assistance □ Yes □ No Fall Risk □ Yes □ No Dizziness/Loss of Balance □ Yes □ No Fall in last 3 months □ Yes □ No

Mobility devise(s) _____

Dietary / Special Needs _____

H/O Aggression and/or combativeness_____

H/O Verbal Inappropriateness_____

Behavior Plan_____

Wanders: □Yes □No Transmitter needed: □Yes □No Transmitter # _____

Medical Decisions □ Yes □ No

CLIENT ATTRIBUTES	Cats	Dogs	Non-Smoker – Client needs non-smoking caregiver	Smoker – Client smokes

ADLs – ACTIVITIES OF DAILY LIVING:

	Bathing		Monitor Ambulation		Support Self-Administered Meds		Laundry		Meal Preparation
	Bathing Supervision		Encourage Fluids		Assist w/Dressing & Undressing		Cleanup Bathroom		Grocery/Errands
	Toileting		Skin Care		Clean Floors (sweep/mop/vacuum)		Cleanup Kitchen		Client transportation
	Toileting Assistance		Apply Lotion		Maintain Clutter-Free Environment		Empty Trash		Transfers
	Incontinence Care		Cleaning		Make bed/Change Linens		Walking Dog		Companionship