



The Epilepsy Center Adult Day Services Enrollment Form

Client Information:

Name _____ Birthdate _____

Address _____

Phone # _____

Enrollment Contact Person _____

Contact Agency _____

Emergency Contact Person _____

Phone # _____

Funding Source: IO ICFMR Level 1 Other _____

Days to attend center: M T W TH F

Guardian Information:

Name _____ Phone # _____

Address _____

For Agency Use

Packet Received ____ / ____ / ____

Reviewed by:

Signature _____ Date _____

____ Enrollment Forms
____ Physical Exam Form
____ Medical Release Form
____ Release of Responsibility

____ Current IP
____ Behavior Plan
____ Notice of Intention
____ Activity Permission Form



General Instructions: Please make sure that the person filling out this series of questions knows the client well. The accuracy of this information is vital to meet the client’s needs while attending The Epilepsy Center’s Adult Day Services.

Social/Behavior and Community Mobility Information

- | | | | |
|---|---|---|-----------|
| 1. Can the client express wants and needs verbally? | Y | N | Sometimes |
| 2. Does the client use sign language? | Y | N | Sometimes |
| 3. Does the client understand simple requests? | Y | N | Sometimes |
| 4. Can the client understand simple sentences? | Y | N | Sometimes |
| 5. Does the client have behavior plan? (Attach) | Y | N | |
| 6. Does the client stay with group activities? | Y | N | Sometimes |
| 7. Does the client have alone time? How much _____ | Y | N | Sometimes |
| 8. Can the client ride public trans. independently? | Y | N | Sometimes |
| 9. Can the client leave and go to the restroom and return to the group independently? | Y | N | Sometimes |
| 10. Does the client demonstrate safe pedestrian skills in the community? | Y | N | Sometimes |
| 11. Does the client need assistance while eating? | Y | N | Sometimes |
| 12. Does the client take his/her meds independently? | Y | N | Sometimes |
| 13. Does the client take care of personal hygiene needs? | Y | N | Sometimes |
| 14. Does the client change clothes independently? | Y | N | Sometimes |
| 15. Does the client take care of toileting needs? | Y | N | Sometimes |
| 16. Does the client interact with peers? | Y | N | Sometimes |
| 17. Does the client develop friendships? | Y | N | Sometimes |
| 18. Does the client set limits with strangers? | Y | N | Sometimes |
| 19. Does the client ask questions when needed? | Y | N | Sometimes |
| 20. Does the client independently plan leisure time? | Y | N | Sometimes |
| 21. Does the client independently carry on a conversation with others? | Y | N | Sometimes |
| 22. Does the client independently engage in hobbies? | Y | N | Sometimes |
| 23. Does the client independently know what to do in case of an emergency? | Y | N | Sometimes |
| 24. Does the client read survival words? | Y | N | Sometimes |
| 25. Does the client require one to one staffing? | Y | N | Sometimes |



Additional Comments:

Enrollment Packet Completed By:

Signature: _____ Date: _____
Print Name _____
Relationship to Client _____

What date will the individual like to begin receiving day services?

Living Situation:

Group Home Supported Living Family Independent

ICFMR Facility

Please attach the most recent copy of the clients IP/ISP and Medical Form.



For Agency Use

Notice of Intention for Adult Day Services for The Epilepsy Center of Northwest Ohio

Clients Name _____
Date of Birth _____

Date of Meeting _____

The above named day services program intends to:

_____ Begin the process of enrolling individual now.

_____ Offer enrollment to the above individual at a later date.

_____ Change days of attendance.

_____ Not offer enrollment to the above individual.

_____ Exit ADS completely.

Reasons: _____

OR

_____ Requests the additional specified information about the individual from the:

_____ service coordinator

_____ parent/guardian



_____ QMRP

Additional Info Requested _____

Release of Responsibility Waiver

Waiver Must Be Signed to Participate

Name _____

Address _____

Telephone _____

Activity _____

I _____ (guardian), acknowledge that participation in events may involve some risk of physical injury due to the nature of the activity. In consideration for acceptance to use the facility and participate in events, I do hereby release and forever discharge, for myself, my heirs, executors and administrators, any and all claims to collect damages which I/my client may incur while participating in events or utilizing the recreation facilities and any and all rights to such damages against The Epilepsy Center of Northwest Ohio or their representatives, employees, officials, directors, sponsors, or any officials of this event.

Signature _____

Date _____



The Epilepsy Center's Adult Day Service Agreement

This agreement will serve as the basis of understanding that will provide Adult Day Services to _____ beginning on _____.

For the duration of this agreement, The Epilepsy Center's Day Services Program agrees to:

1. Provide services that will help clients socialize and develop skills through classes/activities both on and off location,
2. Coordinate and provide transportation and day habilitation services as specified in his/her IP.
3. Participate in IP meetings.
4. Report all incidents required.
5. Arrange for emergency medical services if needed and inform guardian/parent immediately.

For the duration of this agreement, The Client Provider agrees to:

1. Assist client to be ready for transportation for The Epilepsy Center's Adult Day Service daily between 9:45am – 10:00am and be able to receive him/her home by 3:10pm.
2. Assure that the client has the necessary money for days activities if needed.
3. Provide medication or service delivery requirement updates that occur.
4. Attend IP/ISP meetings.
5. Inform The Epilepsy Center's Adult Day Services of all IP/ISP meetings at least four weeks in advance when applicable and as much as possible for any specialized meetings.

For the duration of this agreement, The Client agrees to:

1. Respect all participants and staff at The Epilepsy Center's Adult Services Program.
2. Bring a lunch unless otherwise notified.
3. Bring money for the chosen day's activities if require a fee.
4. Practice good personal hygiene and dress appropriately for activities and weather conditions.

Participant _____ Date _____

Provider _____ Date _____

The Epilepsy Center's Adult Day Services
Representative _____ Date _____

Guardian _____ Date _____

Parent _____ Date _____



Cc: Participant
Provider
Guardian
Parent