

**Silver Club Memory Program Intake Form**

Referral Source/How did you hear about Silver Club? Click or tap here to enter text.

Date Form Filled Out/updated: Click or tap to enter a date.

# Demographic Information

**Club Member Full Name:** Click or tap here to enter text.

Gender: [ ]  Female [ ]  Male [ ]  Prefer not to say [ ]  Other: \_\_\_\_\_\_\_\_

Do you consider yourself to be transgender or gender non-conforming? [ ]  Yes [ ]  No

Client Sexual Orientation: [ ]  Straight [ ]  Lesbian [ ]  Gay [ ]  Bisexual [ ]  Prefer Not to Say [ ]  Unknown

Address:Click or tap here to enter text.

City:Click or tap here to enter text. Zip:Click or tap here to enter text. DOB: Click or tap here to enter text. Age:Click or tap here to enter text.

Phone:Click or tap here to enter text.

Ethnicity: [ ]  Black/African American [ ]  Caucasian [ ]  Hispanic/Latino [ ]  Asian [ ]  Native Hawaiian/Pacific Islander [ ]  American Indian/Alaskan Native [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_

Hispanic: [ ]  Yes [ ]  No

If Multiracial, check all that apply: [ ]  Black/African American [ ]  Caucasian [ ]  Hispanic/Latino [ ]  Asian [ ]  Native Hawaiian/Pacific Islander [ ]  American Indian/Alaskan Native

Relationship Status: [ ]  Single [ ]  Married [ ]  Widowed [ ]  Divorced [ ]  Other

Veteran: [ ]  Yes [ ]  No Branch:­\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse of a Veteran: [ ]  Yes [ ]  No

Religious Affiliation: Click or tap here to enter text.

Clergy Name & Address:Click or tap here to enter text.

[ ]
# Living Situation

[ ]  Alone [ ]  With Caregiver [ ]  Independent [ ]  Assisted Living [ ]  Group Home Contact Name:Click or tap here to enter text. Relationship to Member: Click or tap here to enter text. Primary Caregiver? [ ]  Yes [ ]  No

If no, who is primary caregiver? (Full Name) Click or tap here to enter text.

Address:Click or tap here to enter text.

City:Click or tap here to enter text. Zip:Click or tap here to enter text.

DOB (00/00/0000):\_Click or tap here to enter text.

Phone: Click or tap here to enter text. Cell: Click or tap here to enter text. Email: Click or tap here to enter text.

Gender: [ ]  Female [ ]  Male [ ]  Prefer not to say [ ]  Other: Click or tap here to enter text.\_\_\_\_\_\_\_\_

Do you consider yourself to be transgender or gender non-conforming? [ ]  Yes [ ]  No

Client Sexual Orientation: [ ]  Straight [ ]  Lesbian [ ]  Gay [ ]  Bisexual [ ]  Prefer Not to Say [ ]  Unknown

Ethnicity: [ ]  Black/African American [ ]  Caucasian [ ]  Hispanic/Latino [ ]  Asian [ ]  Native Hawaiian/Pacific Islander [ ]  American Indian/Alaskan Native [ ]  Other Click or tap here to enter text. \_\_ \_\_\_\_\_\_\_\_\_\_\_

Hispanic: [ ]  Yes [ ]  No

If Multiracial, check all that apply: [ ]  Black/African American [ ]  Caucasian [ ]  Hispanic/Latino [ ]  Asian [ ]  Native Hawaiian/Pacific Islander [ ]  American Indian/Alaskan Native

Relationship Status: [ ]  Single [ ]  Married [ ]  Widowed [ ]  Divorced [ ]  Other

Veteran: [ ]  Yes [ ]  No Branch:­Click or tap here to enter text. Spouse of a Veteran: [ ]  Yes [ ]  No

**Contact Tree/Emergency Contact List** (called in order) Children, Relatives, and Friends:

**Name Address Telephone Relationship Email**

1) Click or tap here to enter text.

2) Click or tap here to enter text.

3) Click or tap here to enter text.

4) Click or tap here to enter text.

# Medical Information

Michigan Medicine Patient? [ ]  Yes [ ]  No CPI # (UM only)

Name of Primary Care Physician: Click or tap here to enter text.

Telephone Number: Click or tap here to enter text. Fax Number:Click or tap here to enter text.

Address: Click or tap here to enter text.

Name of Specialist Physician (I.E- Neurologist, Gerontologist): Click or tap here to enter text.

Telephone Number: Click or tap here to enter text. Fax Number: Click or tap here to enter text.

Hospital of Choice: Click or tap here to enter text.

Health Insurance Information: \_Click or tap here to enter text.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Long-Term Care Insurance Information (Name):\_\_Click or tap here to enter text.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: Click or tap here to enter text.

Pharmacy Location: Click or tap here to enter text. Pharmacy Phone #:Click or tap here to enter text.

Dementia Diagnosis? [ ] Yes [ ] No

What type: [ ] Alzheimer’s [ ] Vascular [ ] Frontotemporal [ ] Lewy Body Dementia

[ ] Mild Cognitive Impairment [ ] Parkinson’s [ ] Other:

Approximately when were they diagnosed? Click or tap here to enter text.

# Medical History

Eating: [ ]  Independent [ ]  Needs Assistance [ ]  Other Mobility: [ ]  Independent [ ]  Cane [ ]  Walker [ ]  Wheel Chair

If in a wheelchair, can he/she transfer alone or how much help is needed? Click or tap here to enter text.

How many falls have they had in the last 6 months? Click or tap here to enter text.

Do they need any assistance in the in the bathroom and/or do they experience any incontinence? If yes, please explain.

 Click or tap here to enter text.

Vision: Do they have any vision impairments? If yes, please explain.Click or tap here to enter text.

Hearing: Do they have any hearing impairments? If yes, please explain.Click or tap here to enter text.

Special Dietary Needs:

 Click or tap here to enter text.

Food Allergies: \_\_Click or tap here to enter text.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostheses Used by Member: *(dentures, hearing aid, glasses, braces, walking aids, etc.)*

Any history or current treatment for:

[ ]  Depression [ ]  Anxiety [ ]  Substance Abuse [ ]  Other mental health:

*Please explain*:

 Click or tap here to enter text.

 Does applicant smoke: [ ] Yes [ ]  No If yes, frequency:

Allergies:

List any chronic or acute illness, *please provide dates if within last 5 years*:

List any surgeries, *please provide dates if within last 5 years*:

List any hospitalizations, *please provide dates if within last 5 years*:

Please list or attach any pertinent health information:

**Directives/Insurance:**

Long Term Care Insurance: [ ] Yes [ ] No Advance Directives [ ] Yes [ ] No

DNR: [ ] Yes [ ] No

Copy for Silver Club Programs: [ ]  Yes [ ] No

Durable Power of Attorney: [ ] Yes [ ] No If yes:Click or tap here to enter text. Guardian: [ ]  Yes [ ] No If yes: Click or tap here to enter text.

# Daily Life

How is the person functioning in daily life?

How would you describe the memory loss? (Give some examples if necessary.)

How would you describe the person in terms of being in a social setting?

[ ]  Anxious [ ]  Easy Going [ ]  Requires one on one [ ]  Prefers small groups

How much time does your relative spend alone? Is the person driving? [ ]  Yes [ ]  No How would they get to Silver Club? \_\_\_\_\_\_\_\_\_\_\_\_\_

Who is in charge of the finances?

# Social History

## The more we know about your relative, the better we will be able to interact with him/her.

Occupation(s):

Date of Retirement: Level of Education:

Birthplace:

Hobbies/Special Interests:

Clubs or Organizations:

Life Accomplishments/ Special Achievements:

Places Traveled/ Favorite Vacation Spots:

Favorite Food/Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Favorite Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Favorite Activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Important Information to help us better know your loved one:

**Home environment information:**

Pets? [ ] Yes [ ] No

Names & Types:

Does your relative have his/her own room? [ ] Yes [ ] No

Smokers in the home? [ ] Yes [ ] No Children in the home? □Yes □No

Names & Ages

Other information about the home environment?

# Other

Would you consider him or her to be low income? [ ]  Yes [ ]  No

What kind of support do you have as a caregiver? (family, support groups, in home care etc.)

Are you a caregiver for more than one person? [ ]  Yes [ ]  No If yes, please explain:

**Other Memory Loss Questions, if relevant:**

1. How long has memory loss been evident?
2. Does the person acknowledge a diagnosis of Alzheimer’s or Dementia?
3. How does the person respond to discussion about his/her memory problem?
4. Is he/she interested in learning more about memory loss?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Physical Health** | **Good** | **Moderate** | **Poor** | **Notes:** |
| Oriented to Person/ Time / Place |  |  |  |  |
| Mobility |  |  |  |  |
| Vision |  |  |  |  |
| Hearing |  |  |  |  |
| Oral Status |  |  |  |  |
| Lower Extremities |  |  |  |  |
| Upper Extremities |  |  |  |  |
| Nutrition/Diet |  |  |  |  |
| Weight |  |  |  |  |
| Balance |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Cognitive Health** | **Good** | **Moderate** | **Poor** | **Notes:** |
| Short Term Memory |  |  |  |  |
| Long Term Memory |  |  |  |  |
| Attention/ Focus |  |  |  |  |
| Recognition of Objects |  |  |  |  |
| Spatial Abilities |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Communication Skills** | **Good** | **Moderate** | **Poor** | **Notes:** |
| Comprehension |  |  |  |  |
| Ability to Verbalize |  |  |  |  |

**Questions or Comments. What do you think Silver Club staff should know about him/her?**

**Signature: Date:**

**Silver Club Participant Financial Information**

## To be considered for the sliding scale, this form must be completed. You may choose to skip this form and pay $22/hour.

Above 300% federal poverty level not eligible for sliding scale Max Monthly Income-

* 1. person household- $3397
	2. person household- $4577

**Participant Name: Date:**

**Name of person(s) completing this form:**

 **We will pay $22/ hour and skip this form Gross Monthly Income:**

**(social security, VA benefits, pensions, alimony, estate or trust funds, interest income, employment, SSI)**

**Participant: $ .00 Spouse: $ .00**

**Total Household Income (participant + spouse) $ .00**

**Assets (optional- not included in calculation of total income for cost sharing purposes): (savings, checking, equity/real estate, stock, CD, IRA, money market, cash value life insurance)**

**Participant: $ .00 Spouse: $ .00**

**Total Assets (participant + spouse) $ .00**

**Current Monthly Household Expenses:**

**(rent, heat, car, electricity, insurance, property tax, credit cards, water/sewage, food, life insurance, other)**

**Participant: $ .00 Spouse: $ .00**

**Total Household Expenses (participant + spouse) $ .00**

**Current Monthly Medical Expenses:**

**(prescriptions, insurance, transportation, doctor visits, over the counter medications, bills, Medicare)**

**Participant: $ .00 Spouse: $ .00**

**Total Medical Expenses (participant + spouse) $ .00**

**Adjusted Monthly Income:**

***Subtract Current Monthly Medical and Household Expenses from the Total Monthly Income***

|  |  |
| --- | --- |
| **Total Monthly Income:** | **$ .00** |
| ***Minus*** |  |
| **Total Household Expenses** | **$ .00** |
| ***Minus*** |  |
| **Total Medical Expenses** | **$ .00** |
| ***Equals*** |  |
| **Adjusted Net Monthly Income** | **$ .00** |

**Fee Agreement per sliding scale $ per/hour**

**------------------------------------------------------------------------------------------------------------------------**

|  |
| --- |
| 10**For Internal Use Only*****Recommendation: Day(s) Requested:*** ***Silver Club Day Program Monday******Mild Memory Loss Programs: Tuesday*** ***Chelsea Coffeehouse Wednesday*** ***Mind Works Thursday*** ***Elderberry Club Friday*** ***Any Available***Date of Free Visit/ Intake: Staff Completing Intake: Initial Contact Date:**Staff Notes:** |
| SC Admission Date: D/C Date:EB Admission Date: D/C Date:CH Admission Date: D/C Date:MW Admission Date: D/C Date: | NAPIS □PP □ CMH □2 or more ADLs □Income Status: □Yes □No |  |
|  | Initials:  |