

**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: |