UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

Silver Club Memory Program Intake Form

Referral Source/How did you hear about Silver Club? _____

Date Form Filled Out/updated: _____

Demographic Information

Club Member Full Name: _____

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:_____

City:_____Zip:_____DOB:_____ Age:_____

Phone:_____

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: _____

Clergy Name & Address: _____

Living Situation

□ Alone □ With Caregiver □ Independent □ Assisted Living □ Group Home

Contact Name:_____

Relationship to Member: _____ Primary Caregiver? □ Yes □ No

If no, who is primary caregiver? (Full Name) _____

Address:_____

City:_____Zip:_____

DOB (00/00/0000):_____

Phone:_____Cell:_____Email: _____

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

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
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Relationship Status: □ Single □ Married □ Widowed □ Divorced □ Other_____

Veteran: □ Yes □ No Branch:_____ Spouse of a Veteran: □ Yes □ No

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

Name	Address	Telephone	Relationship	Email
1)				
2)				
3)				
4)				
5)				

Medical Information

Michigan Medicine Patient? □ Yes □ No CPI # (UM only)_____

Name of Primary Care Physician: _____

Telephone Number: _____ Fax Number: _____

Address: _____

Name of Specialist Physician (I.E- Neurologist, Gerontologist): _____

Telephone Number: _____ Fax Number: _____

Hospital of Choice: _____

Health Insurance Information: _____

Long-Term Care Insurance Information (Name):_____

Pharmacy Name: _____

Pharmacy Location: _____ Pharmacy Phone #:_____

Dementia Diagnosis? □Yes □No

What type: □Alzheimer's □Vascular □Frontotemporal □Lewy Body Dementia

□Mild Cognitive Impairment □Parkinson's □Other: _____

Approximately when were they diagnosed? _____

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?

_____

How many falls have they had in the last 6 months? _____

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

_____

_____

Vision: Do they have any vision impairments? If yes, please explain._____

_____

Hearing: Do they have any hearing impairments? If yes, please explain._____

_____

Special Dietary Needs:

_____

_____

Food Allergies: _____

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:

_____

_____

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:_____

Guardian: □ Yes □No If yes: _____

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

<u>Current Monthly Medical Expenses:</u>
(prescriptions, insurance, transportation, doctor visits, over the counter medications, bills, Medicare)

Participant: $_____.00 Spouse: $_____.00

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

<u>Adjusted Monthly Income:</u>

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

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For Internal Use Only

Recommendation:
_____ ***Silver Club Day Program***
Mild Memory Loss Programs:
_____ ***Mind Works***
_____***Elderberry Club***

Day(s) Requested:
_____ ***Monday***
_____ ***Tuesday***
_____ ***Wednesday***
_____ ***Thursday***
_____ ***Friday***
_____ ***Any Available***

Date of Free Visit/ Intake:
Staff Completing Intake:
Initial Contact Date:

Staff Notes:

SC Admission Date:
EB Admission Date:
CH Admission Date:
MW Admission Date:

D/C Date:
D/C Date:
D/C Date:
D/C Date:

NAPIS □
PP □
CMH □
2 or more ADLs □
Income Status: □Yes □No

Initials: _____