GRACE
Adult Day Health Care

Dear Applicant,

Thanks for your interest in Grace Adult Day Health care; we look forward to partner with you and your family in your life journey.

Enclosed, please find the application package you have requested. If you have any question, feel free to contact our social work department for assistance (408) 731-8686, Ext 104. The Grace Intake coordinator will contact you upon receiving your application.

Here is what you need to apply:

If you already belong to a Managed Health Plan, please visit your health care provider to complete Grace Physician Health Assessment form along with TB clearance. Completed package can be faxed, mailed or hand delivered.

If you don't yet belong to a Managed Health Plan please contact: 1-844-580-7272

- Santa Clara County residents can choose between Anthem Blue Cross and Santa Clara Family Health Plan.
- Alameda County residents can choose between Anthem Blue Cross and Alameda Alliance.
- For Farsi please call :1-800-840-5034
- For Mandarin please call :1-800-576-6885
- For Vietnamese please call : 1-800-430-8008
- For Spanish please call : 1800-430-3003

Who is Eligible?

Individuals may be eligible:

- If they have a medical condition that requires treatment or rehabilitative services prescribed by a physician and;
- A physical and/or mental impairment that handicap activities of daily living, but not so serious as to require 24-hour institutional care and;
- A reasonable expectation that preventative services will maintain or improve the present level of functioning and;
- A high chance of further deterioration and probable institutionalization if ADHC services were not available.

What is The Program Cost?

For those persons eligible, Medi-Cal, or Managed Health Plan, or VA, or LTC Insurances may cover the entire program cost.

For Private Pay clients without Medi-Cal insurance, you only need to complete the application along with the TB test. To get more information and cost for Private Pay clients, please call the center at (408) 731-8686.

Meals and Transportation

Nutritious breakfast, hot lunch and snacks are provided every day. Safe, reliable, door-to-door transportation is also provided in most areas of Santa Clara County, as well as city of Fremont.

GRACE ADULT DAY HEALTH CARE

Participant Information

Participant Name:			
Date of Birth:	SSN:		
Current Address:			
City:	Zip	Cell: Home:	
Medical Number:	MCO: #		Medicare Number:

Emergency/Primary Caregiver Contact

Primary Contact Name:			
Address			
City:	Zip	Cell: Home:	
Email Address:		Relationship:	
Secondary Contact Name:			
Address			
City:	Zip	Cell: Home:	
Email Address:		Relationship:	

Health Care Provider Information

Primary Care Doctor: Tel:	Specialists:
Preferred Hospital:	Specialists:
Durable Power of attorney:	IHSS hours: Provider Name:

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Dear Health Care Professional,

Your patient has applied to join Grace Adult Day health Care Center. We would like to thank you in advance for your time and referral. We look forward to partner with you to help caring for your patient. We will stay in communication and update you with any change in mental and physical health condition of your patient. We hope the below information give you a good idea about Grace Adult Day Health Care Services.

The primary objectives of the program:

The Program stresses partnership with the participant, the family and/or caregiver, the primary care physician, and the community in working toward maintaining personal independence

- Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
- Delay or prevent inappropriate or personally undesirable institutionalization.

Quick program overview:

Grace ADHC is licensed by the California Department of Public Health and certified by California Department of Aging. Grace ADHC is an approved Community Based Adult Services (CBAS) provider. Our program consists of a multidisciplinary team of healthcare professionals who conduct a comprehensive assessment of each participant to determine and plan services needed to meet the individual's specific health and social needs. Services provided at the center include the following:

- Professional Nursing Services
- Physical, Occupational and Speech Therapies
- Mental Health Services
- Therapeutic Activities
- Social Services
- Personal Care
- Hot Meals and Nutritional Counseling
- Door-to-Door transportation for most areas of Santa Clara County

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- A reasonable expectation that preventative services will maintain or improve the present level of functioning and;
- A high chance of further deterioration and probable institutionalization if ADHC services were not available.

We are always striving to do our best, and your input is of great value. Please do not hesitate to contact us if you wish to discuss any of this information in more depth. We are looking forward to seeing you at our center when your time allows.

GRACE Adult Day health Care (CBAS)

PHYSICIAN'S HEALTH ASSESSMENT/MEDICAL INFORMATION AND AUTHORIZATION FOR TREATMENT

Patient Name: _____ □ Male □ Female DOB: _____/_____/_____ Exam Date: _____/_____/___

Patient Address: _____ Phone: _____

DIAGNOSES/CONDITIONS: Reflecting the patient's health status (Please complete or attach electronic health record)

Neuro / Cognitive
□ Alzheimer's Disease □ Cognitive Impairment
□ CVA □ Dementia
□ Developmental Disabled □ Neuropathy
□ Parkinson's □ Seizures
□ Other:

Cardiovascular
□ Arrhythmia □ A-fib □ Anemia □ Angina
□ CAD □ CABG □ CHF □ MI
□ HTN □ PVD
□ Other:

Endocrine / Metabolic
□ Diabetes Mellitus: __ Type 1 or __ Type 2
□ Hyperlipidemia □ Hyperthyroidism
□ Hypothyroidism □ Neuropathy
□ Retinopathy □ Nephropathy
□ Other:

Musculoskeletal
□ Chronic Back Pain □ Joint Replacement
□ Osteoarthritis □ Osteoporosis
□ Spinal Stenosis □ Gout
□ Other:

Pulmonary / Respiratory
□ Asthma □ Chronic Bronchitis
□ COPD □ Emphysema
□ Other:

Gastrointestinal / Genitourinary
□ Chronic Liver Disease □ Chronic Kidney Disease □ GERO
□ Hemorrhoids □ PUD □ BPH □ UTI
□ Other:

Behavioral Health
□ Anxiety □ Bipolar □ Depression
□ Schizophrenia □ Agitation □ PTSD
□ Other:
Name of Other Treating MD if known: _____

Other Conditions
□ Cataracts □ Difficulty Swallowing □ Insomnia
□ Glaucoma □ Hearing Loss □ Low Vision
□ Skin Breakdown □ Blindness □ Aphasia
□ Other: □ Ataxia

PHYSICAL EXAMINATION – Please write your comments (Complete or attach EHR)

HEENT:	Gastrointestinal: □ Incontinence Bowel
Respiratory:	Genitourinary □ Incontinence Bladder
Cardiovascular: □ AICD □ Pacemaker	Musculoskeletal:
Breast/Chest	Integumentary:
Neurological	Significant Physical Limitations:

Temp: _____ Pulse: _____ Resp Rate: _____ BP: _____ Height: _____ Weight: _____

TB Screening (within last 12 months) PPD Date: ____/____/_____ Result: _____ Or CXR Date: ____/____/_____ Result: _____

Allergies (Medications & Environment): _____

MEDICATIONS

Medication	Dosage	Route	Freq.	Medication	Dosage	Route	Freq
1				7			
2				8			
3				9			
4				10			
5				11			
6				12			

GRACE Adult Day health Care (CBAS)

PHYSICIAN'S HEALTH ASSESSMENT/MEDICAL INFORMATION AND AUTHORIZATION FOR TREATMENT

Patient Name: _____

1. Unsteady Gait □ Yes □ No
2. Any known history of falls? □ Yes □ No
3. Medication non-compliance? □ Yes □ No
5. Recent hospitalization? (W/in 6 mo.'s) □ Yes □ NO
6. Any Significant Medical History □ Yes □ NO
7. Any Known Evidence of Communicable Disease □ Yes □ No

4. Is this patient capable of self-administration of medications? □ Yes □ No

(If no, Grace licensed nurse to administer medications during program hours)

Please describe any "Yes" answers if details are known: _____

STANDING ORDERS (PCP, please strike through any orders not approved and write in the alternate orders as desired)
Acetaminophen 325 mg 1 tab PO Q4 hrs. prn mild pain or 2 tabs PO Q4 hrs. prn moderate - severe pain
Acetaminophen 500 mg1tabPOQ4hrsprnmildpainor2tabsPOQ4hrsprnmoderate-severepain
Annual influenza virus vaccine injection per CDC recommendations (if offered at ADHC/CBAS center)
OTC Antacid Name: per package instructions for indigestion
Ibuprofen 200 mg 1 tab PO Q4 hrs. prn mild pain w/ food or 2 tabs PO Q4 hrs. prn moderate-severe pain w/ food
EmergencyO2 at 2or4L/min. nasal cannula prn
Loperamide 2 mg PO as per package directions prn diarrhea
Minor wound protocol: cleanse w/ normal saline; apply antibiotic ointment; cover with dry dressing prn
Non-enteric coated ASA 81 mg per MI protocol PO 1X
"Do Not Resuscitate Order" on File: □ Yes □ No
Additional or Alternative Orders:

VITAL PARAMETERS	**DIET ORDER**
MD may adjust by entering desired parameter(s) for notification.	□ Regular □ No added salt □ No Concentrated Sweets □ Renal □ Coumadin Diet □ Fluid Restriction □ Others_____
Systolic Blood Pressure: 80 - 170 Diastolic Blood Pressure: 50 - 110 Pulse: 50 - 110 □ **Blood Pressure: _____ and ↑ _____ Frequency: _____ Per Week** Random Blood Glucose: 60 – 300 □ **Blood Sugar: _____ and ↑ ____Test Frequency: _____Per Week**	Center may deviate from No Concentrated Sweets diet order up to two times a month (special occasions) DIET TEXTURE: □ Regular □ Chopped □ Puréed □ Thickened Liquids □ Other: _____ Any known food restrictions? □ Yes □ No Specify:
Note: NIDDM RBS monthly/IDDM RBS weekly/prn symptoms *unless otherwise ordered.*	
Alternative orders:	

REQUEST FOR ADULT DAY HEALTH CARE / CBAS SERVICES SECTION (must be completed and signed by PCP)

All patients receive the following on each day of attendance: skilled nursing, social services (PRN), personal care (PRN), therapeutic activities and meal services. Additional services, provided as needed, include physical therapy, occupational therapy, speech therapy, mental health services and transportation, based on multidisciplinary team assessment. ADHC / CBAS services are ongoing unless otherwise indicated.

1. Indicate contraindications for receiving any of the above additional services: □ None
   If so, explain_____
2. Are there any medical contraindications for one-way transportation more than 60 minutes? □ None
3. Overall health prognosis? _____
4. Overall therapeutic goals? _____

This patient has one or more chronic or post acute conditions that require monitoring, treatment or intervention, without which there is a high potential for further deterioration and may require emergency room, hospitalization or institutionalization. The information provided reflects this patient's current health status. I request ADHC / CBAS services in addition to authorizing the standing orders.

Print PCP Name: _____ Signature: _____ Date: _____

PCP Tel: _____ PCP Fax: _____ PCP Email: _____

GRACE Adult Day Health Care

3010 Olcott Street Santa Clara, CA 95054 - Tel: (408) 731-8686, Fax: (408) 727-7020