



11010 W. Hampton Ave. Milwaukee, WI 53225 Phone: 414-988-2503 | Fax: 414-988-2508

Adult Day Care Interest & Intake Form
2 FREE DAY TRIAL

Section 1 – Participant Information

Participant Name	
Date of Birth	
Gender	☐ Male ☐ Female ☐ Other
Social Security No.	
Primary Language	☐ English ☐ Hmong ☐ Lao ☐ Burmese ☐ Karen ☐ Other
Address/State/Zip Code	
Phone Number	
Resides At	☐ Private residence ☐ Group home/facility ☐ Other
Name of Group Home/Facility (if apply)	
Owner or House Manager (if apply)	
Owner or House Manager Email (if apply)	

Section 2 – POA/Legal Guardian

Name	
Relationship	
Phone Number	
Address/State/Zip Code	
Email Address	



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Section 3 – Emergency Contact

Emergency Contact Name	
Relationship	
Phone Number	
Address/State/Zip Code	

Section 4 – Insurance Information

Medicare Number	
Medicaid Number	
MCO:	☐ My Choice ☐ Community Care ☐ iCare ☐ Inlusa ☐ Other
Case Worker's Name and Phone Number	
Other Insurance	

Section 5 – Trial Visit Information

Trial Date #1	
Trial Date #2	

Section 6 – Physician Information

Primary Physician	
Phone Number	
Fax Number	

Section 7 – Medical Information

(Please check all that apply)

Neurological / Cognitive Conditions

- ☐ Alzheimer's Disease
☐ Dementia (other type)

- ☐ Parkinson's Disease
☐ Stroke / CVA
☐ Traumatic Brain Injury (TBI)
☐ Memory Loss / Mild Cognitive Impairment

- ☐ Seizure Disorder / Epilepsy



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Cardiovascular Conditions

- ☐ Hypertension (High Blood Pressure)
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary Artery Disease
- ☐ Heart Attack History

Respiratory Conditions

- ☐ COPD
- ☐ Asthma
- ☐ Shortness of Breath

Endocrine / Metabolic Conditions

- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Obesity

Musculoskeletal Conditions

- ☐ Arthritis / Osteoarthritis
- ☐ Osteoporosis
- ☐ Chronic Pain

- ☐ Joint Replacement (Hip/Knee)

Mental Health Conditions

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Active Behavioral Plan

Functional / Safety Concerns

- ☐ Fall Risk
- ☐ Balance Problems
- ☐ Limited Mobility
- ☐ Incontinence

Other Diagnoses

- ☐ Other: _____

Does the participant have a history of:

- ☐ Wandering
- ☐ Aggressive behavior
- ☐ Frequent falls
- ☐ Hospitalizations in the past 6 months

Uses the following:

- ☐ Hearing aids
- ☐ Glasses
- ☐ Walker
- ☐ Cane
- ☐ Dentures
- ☐ Wheelchair (self-propelled)
- ☐ Wheelchair (assist required)

Transfers:

- ☐ Independent
- ☐ Supervision
- ☐ 1-person assist
- ☐ 2-person assist

Allergies: ☐ Dairy ☐ Peanuts ☐ Soy ☐ Fish ☐ Shellfish ☐ Latex ☐ Other: _____

Diet: ☐ Regular ☐ Diabetic ☐ Low Sodium ☐ Puree ☐ Chopped ☐ Other: _____

Section 8 – Activities of Daily Living (ADLs)

- ☐ Ambulation Assistance
- ☐ Toileting Assistance
- ☐ Dressing Assistance
- ☐ Eating Assistance
- ☐ Medication Reminder
- ☐ Other: _____

Section 9 – Medications Taken at Program

Medication Requirements

All **prescribed medications** requiring staff assistance must have a completed Medication Authorization Form signed by the participant, physician (if required), or legal representative.

Over-the-counter (OTC) medications (e.g., Tylenol, Motrin, aspirin, antacids) may be provided as needed (PRN) in accordance with labeled directions and with proper authorization on file.



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All medications must be:

- Clearly labeled with the participant's name, medication name, and dosage
- In the original pharmacy or manufacturer container

Authorization (Select One) I hereby indicate my preference regarding medication management:	☐ I authorize trained staff (RN or designated personnel) to assist with or administer medications as prescribed ☐ I do NOT authorize staff to administer medications ☐ I am able to self-administer my medications (with physician approval, if applicable) ☐ I will take all medications at home prior to attending the program
Participant Responsibility	• I agree to provide accurate and current medication information • I will notify staff of any changes to medications • I understand it is my responsibility (or my representative's) to ensure medications are supplied and replenished as needed
Liability Acknowledgment	I understand that Tswv Chao Vang Center, LLC staff will follow physician orders and standard procedures when assisting with medications. To the extent permitted by law, I agree to hold the Center harmless from liability related to medication assistance, except in cases of negligence or willful misconduct. Participant / Legal Representative Signature: _____ Date _____

Medication	Dosage	Frequency	Notes

Section 10 – Participant Rights

Be treated with dignity and respect

Be free from abuse or neglect



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Participate in service planning
Maintain privacy and confidentiality

Refuse participation in activities
File complaints without retaliation

Section 11 – Photo Consent

☐ I authorize photos/videos for program promotion

☐ I do NOT authorize photo use

Section 12 – Emergency Medical Consent

In the event of a medical emergency, I agree that staff may contact EMS and arrange hospital transport.

Section 13 – Certification and Acknowledgment

I certify that the information provided on this Interest and Intake Form is true, complete, and accurate to the best of my knowledge. I understand that this information will be used by Tswv Chao Vang Center, LLC to determine eligibility for services and to assist in developing an appropriate care plan for participation in the Adult Day Care program.

I acknowledge that submitting this form does not guarantee admission to the program. Admission is subject to assessment, program suitability, and availability.

I understand that the Center may request additional medical documentation, physician clearance, or care coordination information before services can begin.

By signing below, I confirm that I have read, understood, and agree to the policies, participant rights, and procedures outlined in this form.

Participant / Legal Representative Signature	Date
Center Staff Signature	Date