SAINT ELIZABETH'S
ADULT DAY CARE CENTERS

Thank you for your interest in St. Elizabeth's Adult Day Care Centers. Attached, you will find the **Participant Enrollment Packet** to begin the process of enrolling your loved one in our program.

As you complete the packet, please be sure to include the following required documents:

- Completed **Enrollment Packet**
- Recent **physician evaluation and medical review**
- Proof of a **negative Tuberculosis (TB) test**
- Your **method of payment** (private pay or benefits)

If you are planning to use benefits from **Aging Ahead**, the **Department of Mental Health (DMH)**, **Medicaid**, or **Veterans programs**, please have your **case manager** contact our billing department to arrange payment. She can be reached at:

Billing Department:
Tandra Brinker-Johnson
TBrinker-Johnson@seadcc.org
314-772-5107 ext. 1002

If you have any questions or need assistance completing the packet, please don't hesitate to reach out. We look forward to supporting you and your family through this process.

Warm regards,

Jason Johnston
Director of Marketing & Enrollments
St. Elizabeth's Adult Day Care Centers
JJohnston@seadcc.org | 314-772-5107 ext. 1006

SAINT ELIZABETH'S
ADULT DAY CARE CENTERS

Participant Enrollment Packet

Welcome to St. Elizabeth's Adult Day Care Center! We are committed to providing compassionate, high-quality care in a safe and engaging environment. Please complete and return all the required forms and provide any requested documentation to help us get started.

Participant & Caregiver Information:

Participant's Name: _____ Date of Birth: _____/_____/_____

Age: _____ Sex: _____ Race: _____

Social Security Number: _____ Medicaid # _____

Number of People in Household: _____

Caregiver / Responsible Party:

Name of Primary Guardian: _____ Relationship: _____

Primary Phone: _____Alternative Phone: _____

Email Address: _____

Address: _____

City: _____ State: _____ ZIP: _____

Emergency Contacts:

1. Name: _____ Phone: _____

   Relationship: _____ Email: _____

   Address_____ City: _____ State: _____ ZIP: _____

2. Name: _____ Phone: _____

   Relationship: _____ Email: _____

   Address_____ City: _____ State: _____ ZIP: _____

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve

Payment Source

How will you pay for Adult Day Care services?

☐ Private Pay – $95 per day
☐ Veterans Benefits
☐ Aging Ahead
☐ Medicaid
☐ Department of Mental Health (DMH)
*If YES, please attach a copy of the document.

Acknowledgment

I understand that any bill incurred under this consent is my responsibility.

Responsible Party Signature: _____

Date: _____

Attendance & Transportation

Preferred Days (Check):

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Participants must be dropped off by 9 AM and picked up no later than 6 PM.

Is transportation needed? ☐ Yes ☐ No (Transportation is only available within a 10-mile radius of the center.)

Health & Daily Living Summary

Diagnoses:

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve

Provide ALL Medications: (List all medications or provide a printed list)

Medication Name	Dosage	Route (oral, topical, etc.)	Frequency / Directions	Indication for Use

Assistive Devices: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Dentures ☐ Hearing Aids

Health Concerns / Conditions (Check all that apply):

☐ Vision Problems ☐ Blindness ☐ Hearing Problems ☐ Deafness ☐ Difficulty with stairs

☐ Walking Problems ☐ Balance issues or dizziness ☐ Colostomy / Ileostomy ☐ Urostomy

☐ Other: _____

Check Functional Support Needs (Check all that apply)**:**

- Toileting: ☐ Yes ☐ No
- Medication Assistance: ☐ Yes ☐ No
- Mobility: Independent, Needs Help, Non-Ambulatory
- Cognitive Issues: Memory Loss, Wandering, Confusion
- Behavioral: Aggression, Combativeness, Verbally Abusive

Daily Routine (TV, hobbies, games, arts, crafts, interests):

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve

Emergency Transport Authorization

Participant Information

Name: _____ Date of Birth: _____

Address: _____

Significant Diagnosis: _____

Please list any mental health or emotional support needs relevant to emergency care:

_____

_____

Preferred Hospital/Treatment Center

Facility Name: _____

Address: _____

List of Medications & Dosages

Medication	Name Dosage	Time Given

Emergency Transport Permission

In an emergency, St. Elizabeth's has permission to transport this participant: Yes / No

Emergency Contacts

Primary Emergency Contact:

Name: _____ Phone Number: _____

Secondary Emergency Contact:

Name: _____ Phone Number: _____

Emergency Medical Consent: I authorize SEADCC to transport the participant to the nearest hospital in case of emergency. Preferred Hospital**:** _____

Signature (Responsible Party): _____

Date: _____

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve

Medication Administration

Medication Administration Acknowledgment:

I am requesting assistance in the administration of the prescribed medications listed above to: Participant Name: _____ while he/she is attending St. Elizabeth's Adult Day Care. I understand the personnel at St. Elizabeth's will only assist with the medication and are not responsible should the participant refuse to take the medication. The staff will inform me if that occurs. (Medications administered per Physician's Order.)

Allergies

Drug Allergies (if any): _____

Food Allergies (if any): _____

Dietary Instructions:

Code Status (circle one) Do Not Resuscitate (DNR) OR Full Code

Does the participant have advanced directives (e.g., living will, durable power of attorney)? Yes / No

Signature (Responsible Party): _____

Date: _____

The form must be revised by the Caregivers every six months

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CACFP ENROLLMENT FORM FOR ADULT DAY CARE CENTERS

CENTER'S INFORMATION

NAME OF ADULT DAY CARE CENTER	PHONE NUMBER

CENTER CONTACT PERSON'S NAME	DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)

PARTICIPANT'S INFORMATION

PARTICIPANT'S FULL NAME	DATE OF BIRTH

FAMILY MEMBER OR GUARDIAN NAME	PARTICIPANT'S STREET ADDRESS

CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER

ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)

ARE YOU OF HISPANIC OR LATINO ORIGIN?

☐ Yes ☐ No

WHAT IS YOUR RACE? (SELECT ONE OR MORE)

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

IN THIS COLUMN, CHECK THE DAYS THE PARTICIPANT USUALLY ATTENDS DAY CARE:		WHAT TIME DOES THE PARTICIPANT USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES THE PARTICIPANT USUALLY LEAVE EACH DAY? CIRCLE AM OR PM	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION:
MON	☐	☐ AM ☐ PM	☐ AM ☐ PM	
TUES	☐	☐ AM ☐ PM	☐ AM ☐ PM	
WED	☐	☐ AM ☐ PM	☐ AM ☐ PM	
THURS	☐	☐ AM ☐ PM	☐ AM ☐ PM	
FRI	☐	☐ AM ☐ PM	☐ AM ☐ PM	
SAT	☐	☐ AM ☐ PM	☐ AM ☐ PM	
SUN	☐	☐ AM ☐ PM	☐ AM ☐ PM	

CHECK WHEN THE PARTICIPANT IS IN CARE AT THIS CENTER

☐ FULL DAY CARE
☐ HALF DAY - MORNING
☐ HALF DAY - AFTERNOON
☐ EVENING CARE

CHECK THE MEALS THE PARTICIPANT IS USUALLY GIVEN AT THIS CENTER

☐ BREAKFAST
☐ MORNING SNACK
☐ LUNCH
☐ AFTERNOON SNACK
☐ SUPPER
☐ EVENING SNACK

CHECK THE HOLIDAYS THE PARTICIPANT IS IN CARE AT THIS CENTER

☐ NEW YEARS DAY
☐ MARTIN LUTHER KING'S BIRTHDAY
☐ LINCOLN'S BIRTHDAY
☐ WASHINGTON'S BIRTHDAY
☐ EASTER
☐ TRUMAN DAY
☐ MEMORIAL DAY
☐ JUNETEENTH
☐ INDEPENDENCE DAY
☐ LABOR DAY
☐ COLUMBUS DAY
☐ VETERAN'S DAY
☐ THANKSGIVING DAY
☐ CHRISTMAS DAY

SIGNATURE OF PARTICIPANT OR GUARDIAN	DATE

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

INCOME ELIGIBILITY FORM FOR ADULT CARE CENTERS

To apply for free and reduced-price meals in an adult care center, complete this form.

PART 1 ENROLLEE INFORMATION

Complete information below for the enrollee at the adult care center. If the participant is a Medicaid, Supplemental Security Income (SSI), or Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamp) participant, complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a Medicaid, SSI, or SNAP case number.

ENROLLEE'S NAME	DATE OF BIRTH

Check all that apply and provide the appropriate case number.

❑ MEDICAID _____ ❑ SSI _____ ❑ SNAP (FOOD STAMPS) _____

PART 2 HOUSEHOLD AND INCOME INFORMATION

Complete information below for all household members. A household member is defined as the adult participant, and if residing with the adult participant, the spouse and dependents of the adult participant. Functionally impaired adults living with their parents are considered a "family" separate from their parents. For each household member, indicate income by source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security.

INCOME BASED ON (CHECK ONE): YEARLY ❑ MONTHLY ❑ 2 X A MONTH ❑ EVERY 2 WEEKS ❑ WEEKLY ❑

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3 RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

AMERICAN INDIAN OR ALASKA NATIVE ❑ ASIAN ❑ BLACK OR AFRICAN AMERICAN ❑ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ❑ WHITE ❑

PART 4 SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT ENROLLEE OR GUARDIAN	SOCIAL SECURITY NUMBER (LAST FOUR DIGITS ONLY) XXX – XX -	DATE SIGNED

(IF NOT ENROLLEE SIGNATURE, RELATIONSHIP OF ADULT TO THE ENROLLEE)

PRINTED NAME OF ADULT

ADDRESS	HOME PHONE NUMBER	WORK PHONE NUMBER

Section 9 of the National School Lunch Act requires that, unless your SNAP, Medicaid, or SSI case number is provided, you must include the last four digits of the social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of the social security number is not mandatory, but if it is not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP, Medicaid, or SSI benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ❑ MONTH ❑ 2 X A MONTH ❑ EVERY 2 WEEKS ❑ WEEKLY ❑ SNAP ❑ SSI ❑ MEDICAID ❑

Eligibility Determination: ❑ Free ❑ Reduced ❑ Paid

SIGNATURE OF CENTER REPRESENTATIVE ►	DATE

SAINT ELIZABETH'S
ADULT DAY CARE CENTERS

PHYSICIAN & MEDICAL REVIEW

Please fax the requested information to:

_____ Arnold Center: 636-206-2849

_____Florissant Center: 314-334-4785

_____Ste. Genevieve Center: 314-664-1605

_____St. Louis Center: 314-772-3674

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve

SAINT ELIZABETH'S
ADULT DAY CARE CENTERS

PHYSICIAN & MEDICAL REVIEW

(To Be Completed by Physician)

Participant Name: _____ Date of Birth (DOB): _____

Date of Last Physical Exam: _____

Is the participant currently free from communicable or contagious diseases/infections? ☐ Yes ☐ No

Diagnoses:

_____

_____

Tuberculosis/TB Test Date: _____ Result: ☐ Negative ☐ Positive

Vital Signs:

Weight: _____ lbs. Blood Pressure: _____/_____ Pulse: _____

Mental Status / Behavior:

_____

Diet Type: ☐ Regular ☐ Mechanical Soft ☐ Pureed ☐ Cut Up

☐ Other:

_____

Please indicate which programs are recommended for the participant (check all that apply):

☐ Social Activities ☐ Therapeutic Work Activities ☐ Activities of Daily Living (ADL) Program

☐ Modified Exercise Program ☐ Recreational Activities

Allergies to food? ☐ Yes ☐ No Allergies to medications? ☐ Yes ☐ No Allergies to latex? ☐ Yes ☐ No

If yes, Explain:

_____

_____

PHYSICIAN & MEDICAL REVIEW

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve

SAINT ELIZABETH'S
ADULT DAY CARE CENTERS

PHYSICIAN & MEDICAL REVIEW – CONT.

(To Be Completed by Physician)

Participant Name: _____ Date of Birth (DOB): _____

Participant Ambulates: (check all that apply):
☐ Independently ☐ With Stand-by Assistance ☐ With Cane ☐ With Walker ☐ With Wheel-chair

Code Status: ☐ Full Code ☐ DNR/Do Not Resuscitate

Medications:

Medication Name	Dosage	Route (oral, topical, etc.)	Frequency / Directions	Indication for Use

Example Entry: PRN Acetaminophen – 500 mg – PO – 2 tabs every 6 hours – Pain/Fever

Physician's Printed Name: _____

Office Address: _____City_____ State_____ ZIP_____

Phone: _____ Fax: _____ Email: _____

Physician's Signature: _____ Date: _____

Information Release: _____Date: _____

Administrative Offices
3683 COOK AVE. ST. LOUIS MISSOURI 63113 | (314) 772-5107 | WWW.SEADCC.ORG
St. Louis City | Florissant | Arnold | Ste. Genevieve