Exhibit 2

Adult Day Health Care: Initial Screening

Days of Attendance:

Arrival/Departure Times:

Jewish Senior *Life*

***services for healthy aging***

**Adult Day Health Care: Initial Screening**

Referral Name:.

Address:.

Phone Number: \_

Medicaid Number: \_ MLTC/MMC Provider:. \_ Contact Person: \_

Social Security Number: \_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare Number:----------- Provider#:--------------

MLTC/MMC Phone Number: \_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:

Name: Phone:. \_ Relationship: \_

Address:

Primary Care Physician:

Phone Number:----------- Fax Number: \_ DNR/MOLST: Yes/No Legal Guardian: Yes/No Health Care Proxy: Yes/No

Preferred Hospital:

Services Needed (Circle All that Apply): PT/OT/Speech

Community Agencies/Services Involved (Name, Agency, Phone Number, Service provided):

Diagnoses/Medical Concerns:

Psychosocial Concerns:

**Support Needs:**

Diet: AIIergies to Food: Yes/No If Yes:

Allergies to Medication: Yes/No If Yes:

***Check all that apply:***

**Mobility:** Walker Wheelchair Cane No Device

**Eating:** None Food Cut Observed Hand Fed

**Bladder:** Continent Incontinent **Pads/Briefs:** Yes/No

**Toileting:** None Some Assist Total Assist

**Bowel:** Continent Incontinent

**Hearing:** Within normal limits wears hearing aids Deaf Difficulty hearing in noisy environment **Vision:** Within functional limits Wears corrective lenses partially impaired vision Legally blind **Communication:** Verbal Non-Verbal Difficult to understand Communication device

Makes needs known can read/write

**Services Requested:\_** Med Admin \_ Med Packing\_ Personal Care\_ Shower\_ Wound Care

\_ Diabetes Mgmt . \_ Routine Labs\_ Special Treatment

**Comments**