**Participant Record**

REQUIREMENTS FOR USE OF THIS SAMPLE DOCUMENT: Adult Day Services license holders are responsible for modifying this sample for use in their program. At a minimum, you must fill in the blanks on this form. You may modify the format and content to meet standards used by your program. This sample meets compliance with current licensing requirements as of **October 1, 2017**. Providers remain responsible for reading, understanding and ensuring that this document conforms to current licensing requirements. DELETE THIS HIGHLIGHTED SECTION TO BEGIN MODIFYING THIS FORM.

1. **Participant Application**

**Person Information**

|  |  |  |
| --- | --- | --- |
| First name: | Last name: | |
| Date of Birth: | Sex: | |
| Address: | Phone number: | Cell number: |

**Admission Information**

|  |  |
| --- | --- |
| Date of Admission: | Date of Readmission: |
| Source of Referral (Name, Address, Phone Number): | |

**Living Arrangement**

|  |
| --- |
| □ Lives alone □ Lives with spouse □ Lives with family  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Emergency contact information #1**

|  |  |
| --- | --- |
| First name | Last name: |
| Office number: | Cell number: |

**Emergency contact information #2**

|  |  |
| --- | --- |
| First name | Last name: |
| Office number: | Cell number: |

**Health care provider contact information**

|  |  |
| --- | --- |
| Primary physician or medical provider name: | |
| Phone number: | Fax number: |

1. **Service Agreement**
2. [Program Name] agrees to provide supervision, administration of medications, assistance with activities of daily living, supervision of personal hygiene, supervised recreational and social activities, a therapy monitored exercise program, and meals and snacks provided by nutrition services as appropriate to the

length of time spent at program each day.

1. Participant and/or Responsible Party agrees to:
   1. Pay the amount listed below for each day of services. Meals and snacks are included in this amount.

□ [Insert rate here] □ [Insert rate here] □ [Insert rate here]

* 1. Pay the additional amount listed below for transportation services (if applicable).

□ [Insert rate here]

* 1. Provide clothing, undergarments, and continence products as needed or desired by the participant.
  2. Provide spending money as needed or desired by the participant.
  3. Provide medications prescribed by the participant’s physician in a pharmacy labeled bottled.

1. **Intake Screening:**

Date of intake screening:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names of persons that were interviewed for intake screening:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date individual was provided notification of outcome of intake screening (within five working days of screening):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is participant capable of self-preservation? □ Yes □ No

1. **Participant’s Rights & Right to Contest**

Person name:

Program name:

□ I received a copy of the center's statement on participants' rights.

When receiving services and supports from this program name, I have the right to:

1. the right to participate in developing one's own plan of care;
2. the right to refuse care or participation;
3. the right to physical privacy during care or treatment;
4. the right to confidentiality of participant records; and
5. the right to present grievances regarding treatment or care in accordance with part [9555.9640](https://www.revisor.mn.gov/rules/?id=9555.9640), item D.

□ The center provided me with written notice ensuring that myself or my guardian/caregiver has been informed of my right to contest the accuracy and completeness of the data maintained in my record.

Date of admission: Date I received this information:

1. **Policy Orientation Acknowledgement**

Orientation to the following policies was received within 24 hours of admission, or 72 hours for persons who would benefit from a later orientation:

* Maltreatment of Vulnerable Adults
* Program Abuse Prevention Plan

Date of admission: Date I received this information:

I received written information on the following:

* the scope of the programs, services, and care offered by the center;
* **§**a description of the population to be served by the center;
* a description of individual conditions which the center is not prepared to accept, such as a communicable disease requiring isolation, a history of violence to self or others, unmanageable incontinence or uncontrollable wandering;
* the participants' rights developed in accordance with part [9555.9670](https://www.revisor.mn.gov/rules/?id=9555.9670) and additionally:
* a procedure for presenting grievances, including the name, address, and telephone number of the licensing division of the department, to which a participant or participant's caregiver may submit an oral or written complaint;
* a copy or written summary of Minnesota Statutes, section [626.557](https://www.revisor.mn.gov/statutes/?id=626.557), the Vulnerable Adults Act;
* the center's policy on and arrangements for providing transportation;
* the center's policy on providing meals and snacks;
* the center's fees, billing arrangements, and plans for payment;
* the center's policy governing the presence of pets in the center;
* the center's policy on smoking in the center;
* types of insurance coverage carried by the center;
* a statement of the center's compliance with Minnesota Statutes, section [626.557](https://www.revisor.mn.gov/statutes/?id=626.557), and rules adopted under that section;
* a statement that center admission and employment practices and policies comply with Minnesota Statutes, chapter 363, the Minnesota Human Rights Act;
* the terms and conditions of the center's licensure by the department, including a description of the population the center is licensed to serve under part [9555.9730](https://www.revisor.mn.gov/rules/?id=9555.9730); and
* the telephone number of the department's licensing division.

Date of admission: Date I received this information:

By signing, I am agreeing that I have read and understand the information in **sections I, II, III, IV, and V**.

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Signature | Title | Date |
|  |  | Participant |  |
|  |  | Participant’s Caregiver |  |
|  |  | Center Director |  |

1. **Needs Assessment**

The needs assessment must be completed **within 30 days of admission** and placed in the participant's record.

Participant’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**§**

The center shall assess the participant's needs for center services based on observation of the participant and information obtained from other sources, including any assessment performed within the prescribed time by a preadmission screening team under Minnesota Statutes, section [256B.0911](https://www.revisor.mn.gov/statutes/?id=256B.0911). The needs assessment shall address the participant’s:

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.2.A.1)

1. psychosocial status (for example, awareness level, personal care needs, need for privacy or socialization):

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.2.A.2)

|  |
| --- |
|  |

1. functional status (for example, endurance and capability for ambulation, transfer, and managing activities of daily living):

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.2.A.3)

|  |
| --- |
|  |

1. physical status, to be determined by observation, from the intake screening interview, and from the medical report received from the participant's physician:

|  |
| --- |
|  |

1. **Preliminary Service Plan**

The preliminary service plan must be completed **within 30 days of admission** and placed in the participant's record.

Participant’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of preliminary service plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The center shall develop a preliminary service plan based on the needs assessment and coordinated with other plans of services for the participant. The preliminary service plan must include the following information and specifications:

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.2.B.1)

1. Scheduled days of participant's attendance at the center:

□ Sunday □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Saturday

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.2.B.2)

1. Transportation arrangements:[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.2.B.3)

□ Center Transportation □ Public Transportation □ Self/Caregiver □Other:\_\_\_\_\_\_\_\_\_\_\_\_

1. Nutritional needs and, where applicable, dietary restrictions:

□ No □ Yes. If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.2.B.4)

1. Role of the participant's caregiver or caregivers in carrying out the service plan:

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.2.B.5)

1. Services and activities in which the participant will take part immediately upon admission:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Individual Abuse Prevention Plan**

The individual abuse prevention plan must be completed **within 30 days of admission** and placed in the participant's record.

1. **Sexual abuse**

Is the person susceptible to abuse in this area? 🞎 Yes (if any area below is checked) 🞎 No

* Lack of understanding of sexuality
* Likely to seek or cooperate in an abusive situation
* Inability to be assertive
* Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Physical Abuse**

Is the person susceptible to abuse in this area? 🞎 Yes (if any area below is checked) 🞎 No

* Inability to identify potentially dangerous situations
* Lack of community orientation skills
* Inappropriate interactions with others
* Inability to deal with verbally/physically aggressive persons
* Verbally/physically abusive to others
* “Victim” history exists
* Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Self Abuse**

Is the person susceptible to abuse in this area? 🞎 Yes (if any area below is checked) 🞎 No

* Dresses inappropriately
* Refuses to eat
* Inability to care for self-help needs
* Lack of self-preservation skills (ignores personal safety)
* Engages in self-injurious behaviors
* Neglects or refuses to take medications
* Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Financial Exploitation**

Is the person susceptible in this area? 🞎 Yes (if any area below is checked) 🞎 No

* Inability to handle financial matters
* Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Is the program aware of this person committing a violent crime or act of physical aggression toward others?** 🞎 Yes 🞎 No

Specific measures to be taken to minimize the risk this person might reasonably be expected to pose to visitors to the program and persons outside the program, if unsupervised:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Plan of Care**

A written plan of care must be developed **within 90 days of admission** by the center staff together with the participant, the participant's caregiver, and other agencies and individual service providers.

Participant’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of plan of care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of update to preliminary service plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If identified in update, additional services required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individuals involved in development of plan of care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Short and long-term objective for the participant. Must be stated in a concrete, measurable, and time specific outcomes. (i.e. Participant will participate in structured exercise for 15 minutes 2 times a week.) [**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.3.A) Outcomes must be developed with person-centered planning and consideration.

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Outcome (short and long-term)** | **Methods** | **Responsible Staff Members** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.3.D)

1. The anticipated duration of the individual plan of care as written: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[**§**](https://www.revisor.mn.gov/rules/?id=9555.9700#rule.9555.9700.3.E)

1. The individual plan of care (section IX) and individual abuse prevention plan (section VIII) must be reviewed quarterly:

|  |  |
| --- | --- |
| **Date of Review:** | **Updates/changes? If yes, explain.** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. **Social History**

**Date Updated (at a minimum of annually): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Background Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_

Synagogue/Church: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role of Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Information:**

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country of Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country of Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings’ Names/Locations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Partner’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Married: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Death/Divorce? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other marriage information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Grandchildren: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Involvement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Significant People: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education & Work History:**

High School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ College/University: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retirement Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Medical Report**

Person name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The medical report must be dated **within the three months prior to or 30 calendar days after** **the participant's admission** to the center.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Description |
| Does participant have dietary restrictions? |  |  |  |
| Does participant have a medication regimen, including the need for medication assistance? |  |  |  |
| May the participant engage in a structured exercise program? |  |  |  |
| Is the person free of communicable disease or infestations, as specified in parts 4605.7000 to 4605.7090 that would endanger the health of other persons? |  |  |  |
| Description of participant’s medical history: |  | | |

The medical report must be signed by a:

1. Physician; or
2. Physician assistant or registered nurse and cosigned by a physician.

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Signature | Title | Date |
|  |  | Physician |  |
|  |  | Physician Assistant or  Registered Nurse |  |

1. The medical report must also include a report on a **physical examination (attach to medical report) that is updated annually.**
2. Notes on special problems or on changes needed in medication and on the need for medication assistance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Attendance Record**

Documentation of actual attendance for each adult day service recipient for which the license holder is reimbursed by a governmental program must be maintained. The records must be accessible to the commissioner during the program's hours of operation, they must be completed on the actual day of attendance, and they must include:

Participant’s name (First, Middle, and Last): ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Date | Time Dropped Off | Time Picked Up |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Progress Notes**

|  |  |  |
| --- | --- | --- |
| **Date** | **Time** | **Notes** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Incident Report**

Date of incident: Time of incident: 🞏 am / 🞏 pm

Location of incident:

Participant name:

Program Name: \_\_\_\_\_\_\_\_License Number: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Incident Type** (check all that apply):

□ Illness

□ Accident requiring first aid

* Medical or psychiatric care
* Police report made
* A report of alleged or suspected vulnerable adult maltreatment (Also refer to Vulnerable Adults Reporting Policy)

1. **Description of incident**:
2. **Description of the center’s action in response to the incident**:

Staff person(s) who responded to the incident:

Name and signature of reporting staff: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Persons Notified**

Participant’s Caregiver:

Name Date Time

Other:

Name Date Time

Other:

Name Date Time

1. **Discharge Summary**

Participant name:

Program Name: \_\_\_\_\_\_\_\_License Number: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of discharge (last date of services):

Reason for discharge: