LifeWorks Member Intake

Name

Formal

☐ Anchorage ☐ Valley

Gender ☐ M ☐ F DOB ☐ Married ☐ Single ☐ Divorced ☐ Widowed

ALH Info

Name of ALH

Private Home ☐

Administrator

Other Residents and their Relationships:

Cell/Room Phone

Home Phone #

Address

Phone

Fax

E-Mail

Legal Representative

Deemed unable to sign for self and make decisions? ☐ Y ☐ N

Name

Role/ Relationship

Phone

E-Mail

Mailing Address

Emergency Family Contacts

	Primary	Secondary
Name		
Relationship		
Phone		
E-Mail		

Care Coordinator

Name

Agency

Work

Cell

Fax

E-Mail

Scheduling Preferences
(mornings, afternoons, number and/or specific days of week):

Health / Medical

Doctor | **Phone** | **Fax**

Other Insurance?

Hospital Pref

Diagnoses

Medications

DNR/ Comfort One? ☐ Y ☐ N

Seizures? ☐ **On seizure meds?** ☐ **Details/ procedure:**

Expiration date of + TB clearance

 # ER visits in the past year **Overall Health Stable?** ☐ Y ☐ N

Explain:

Health & Social Concerns

Assistance needed in any of these areas? Explain

Vision

Hearing

Communication (language & style)

Food/Drink Restrictions

Allergies

Special diet? ☐

No Lunch at HH? ☐

circle all that apply — **Diabetic** **Renal** **Soft Foods** **Choking Risk** **Other (indicate):**

Continent? ☐ Y ☐ N **Need prompting/ direction?** ☐ Y ☐ N **Catheter?** ☐ **Colostomy?** ☐

Ambulatory? ☐ Y ☐ N **Strong?** ☐ Y ☐ N **L or R side weak/ paralyzed?**

Uses Walker? ☐ ☐ Large ☐ Small **Uses Wheelchair?** ☐ **Motorized?** ☐

Capable of SELF RESCUE? ☐ Y ☐ N

Transferring Assistance (independent, 1- or 2-person assist,, gait belt, toilet/ vehicle assistance)

Background and Goals

Goals: Physical

Goals: Cognitive

Goals: Social

Background (family, work, residences)

Interests

Native-Alaskan? ☐ **Corporation?** _____ **Religion/ spirituality** _____

Native-American? ☐ **Tribe?** _____ **Ethnicity** _____

Questions for third parties, if applicable:

Do Not Resuscitate/ Comfort One? ☐

Low awareness? ☐

Weak memory? ☐

Become agitated? ☐

Disturbed emotionally? ☐

Isolation tendencies? ☐

Wanders? ☐ **When?** _____

Regarding the client's past and present actions:

Alcohol abuse? ☐

Verbally abusive? ☐

Physically abusive? ☐

Sexual offender? ☐

Explain

LifeWorks
Service Agreement

Member _____ DOB _____

Legal Representative _____ Relationship _____

Phone _____

Care Coordinator _____ Phone _____

Unless otherwise stated, members with POAs are permitted to sign their own paperwork and make their own decisions, while members with guardians and conservators need these representatives to make their decisions and sign for them.

- Deemed unable to sign for self and make decisions? ☐ Y ☐ N

Photo Publication. Social Media Consent and Release of Responsibility
I grant LifeWorks (LWs) permission to take photo images, print them, and publish them on LWs internal communications, website, newsletter bulletins, Facebook page, Instagram, and other LWs publications, removing any other personal identification.

This permission also includes taking photographs of medical and/or equipment related incidents as required, which will only be shared with the representatives listed above and/or the Adult Protective Services.

If checked Yes (Y), I hereby release LWs, from any claims generated in connection with defamation, invasion of privacy, and violation of any statutory rights as it relates to photos.

- OK to publish photo? ☐ Y ☐ N

Bathroom Assistance Protocol
LWs will assist members in the bathroom who are able to bear weight and/or can transfer to the toilet with assistance of one or two LWs staff.

LWs staff will *not* provide assistance to members that (1) cannot bear weight, (2) need a Hoyer lift to transfer, and/or (3) need to be changed while lying down.

In situations of this nature the member's home must ensure that member's bathroom needs are met. The member must be clean and dry prior to LWs staff arrival to transport the member to the Adult Day Center (ADS). If the member becomes incontinent while at the ADS, a designated LWs staff will contact the home to inform them that the member will be returning early to be changed and cleaned in the comfort of their home.

Non Transfer Agreement
In the event that LWs staff is not able to provide the above assistance, I understand that the member will not be transferred for bathroom use while attending LifeWorks. I or the caregiver in the home will arrange for someone to be at home in the event the member is incontinent and needs to return home early to be changed.

- Please initial _____

Notice: LifeWorks has a non-smoking campus located at 500 W international Airport Rd. in Anchorage. The Adult Day Centers located at 744 E 13th Ave in Anchorage and 951 E Bogard Rd in Wasilla have designated smoking areas.

_____ _____
Member/Legal Representative Signature Date

_____ _____
Witness Signature Date

For office use only:
Non-transfer agreement on file. ☐ Y ☐ N ☐ N/A

LifeWorks
Release of Information (ROI)

Member		DOB	
Legal Representative		Relationship	
ALH		Phone	
Emergency/Family Contact		Phone	
Other Contact		Phone	
Care Coordinator		Phone	
Doctor		Phone	
Hospital Preference			

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My Authorization
In case of an emergency, I authorize LifeWorks (LWs) personnel to initiate medical assistance and to contact the individuals listed above.

To Grant Emergency Medical Consent
The legal representative and/or the individuals listed above will be updated on all emergency changes. I hereby grant LWs personnel authorization to: (1) call a physician, (2) select and call an appropriate emergency medical response team, and/or (3) arrange transportation to the nearest hospital.

Also, I authorize LWs designated personnel to release any and all information related to the emergency. I agree to be responsible for all incurred medical expenses related to the emergency.

Release of Confidential Information
In the best interest of my care, I authorize LWs designated personnel to discuss my confidential information and the status of my well-being with the representatives listed above as well as communicate with the Department of Public Assistance about my Medicaid status.

My Rights
I understand that I may revoke this authorization at any time by notifying the organization releasing this information in writing.

I understand that uses and disclosures already made will not have any effect on actions taken on this authorization before my revocation was received.

I understand that I may request a copy of this signed authorization. A copy of this authorization is as valid as the original.

This consent is automatically terminated when my services are terminated with LWs.

_____ _____
Member/Legal Representative Signature Date

_____ _____
Witness Signature Date

For office use only:
Do Not Resuscitate (DNR) /Comfort One on file with LWs ☐