



Silver Club Memory Program Intake Form

Referral Source/How did you hear about Silver Club? _____

Date Form Filled Out/updated: _____

Demographic Information

Club Member Full Name: _____

 Gender: Female Male Prefer not to say Other: _____

 Do you consider yourself to be transgender or gender non-conforming? Yes No

 Client Sexual Orientation: Straight Lesbian Gay Bisexual Prefer Not to Say Unknown

Address: _____

City: _____ Zip: _____ DOB: _____ Age: _____

Phone: _____

 Ethnicity: Black/African American Caucasian Hispanic/Latino Asian
 Native Hawaiian/Pacific Islander American Indian/Alaskan Native Other _____

 Hispanic: Yes No

 If Multiracial, check all that apply: Black/African American Caucasian Hispanic/Latino Asian
 Native Hawaiian/Pacific Islander American Indian/Alaskan Native

 Relationship Status: Single Married Widowed Divorced Other _____

 Veteran: Yes No Branch: _____ Spouse of a Veteran: Yes No

Religious Affiliation: _____

Clergy Name & Address: _____

Living Situation

Alone With Caregiver Independent Assisted Living Group Home

Contact Name: _____

Relationship to Member: _____ Primary Caregiver? Yes No

If no, who is primary caregiver? (Full Name) _____

Address: _____

City: _____ Zip: _____

DOB (00/00/0000): _____

Phone: _____ Cell: _____ Email: _____

Gender: Female Male Prefer not to say Other: _____

Do you consider yourself to be transgender or gender non-conforming? Yes No

Client Sexual Orientation: Straight Lesbian Gay Bisexual Prefer Not to Say Unknown

Ethnicity: Black/African American Caucasian Hispanic/Latino Asian
 Native Hawaiian/Pacific Islander American Indian/Alaskan Native Other _____

Hispanic: Yes No

If Multiracial, check all that apply: Black/African American Caucasian Hispanic/Latino Asian
 Native Hawaiian/Pacific Islander American Indian/Alaskan Native

Relationship Status: Single Married Widowed Divorced Other _____

Veteran: Yes No Branch: _____ Spouse of a Veteran: Yes No

Contact Tree/Emergency Contact List (called in order) Children, Relatives, and Friends:

<u>Name</u>	<u>Address</u>	<u>Telephone</u>	<u>Relationship</u>	<u>Email</u>
-------------	----------------	------------------	---------------------	--------------

1) _____

2) _____

3) _____

4) _____

5) _____

Medical Information

Michigan Medicine Patient? Yes No CPI # (UM only) _____

Name of Primary Care Physician: _____

Telephone Number: _____ Fax Number: _____

Address: _____

Name of Specialist Physician (I.E- Neurologist, Gerontologist): _____

Telephone Number: _____ Fax Number: _____

Hospital of Choice: _____

Health Insurance Information: _____

Long-Term Care Insurance Information (Name): _____

Pharmacy Name: _____

Pharmacy Location: _____ Pharmacy Phone #: _____

Dementia Diagnosis? Yes No

What type: Alzheimer's Vascular Frontotemporal Lewy Body Dementia

Mild Cognitive Impairment Parkinson's Other: _____

Approximately when were they diagnosed? _____

Medical History

Eating: Independent Needs Assistance Other _____

Mobility: Independent Cane Walker Wheel Chair

If in a wheelchair, can he/she transfer alone or how much help is needed?

How many falls have they had in the last 6 months? _____

Do they need any assistance in the in the bathroom and/or do they experience any incontinence? If yes, please explain.

Vision: Do they have any vision impairments? If yes, please explain. _____

Hearing: Do they have any hearing impairments? If yes, please explain. _____

Special Dietary Needs:

Food Allergies: _____

Prostheses Used by Member: (*dentures, hearing aid, glasses, braces, walking aids, etc.*)

Any history or current treatment for:

Depression Anxiety Substance Abuse Other mental health: _____

Please explain:

5

Does applicant smoke: Yes No If yes, frequency: _____

Allergies:

List any chronic or acute illness, *please provide dates if within last 5 years:*

List any surgeries, *please provide dates if within last 5 years:*

List any hospitalizations, *please provide dates if within last 5 years:*

Please list or attach any pertinent health information:

Directives/Insurance:

Long Term Care Insurance: Yes No

Advance Directives Yes No

DNR: Yes No

Copy for Silver Club Programs: Yes No

Durable Power of Attorney: Yes No If yes: _____

Guardian: Yes No If yes: _____

Daily Life

How is the person functioning in daily life? _____

How would you describe the memory loss? (Give some examples if necessary.) _____

How would you describe the person in terms of being in a social setting?

- Anxious Easy Going Requires one on one Prefers small groups

How much time does your relative spend alone? _____

Is the person driving? Yes No How would they get to Silver Club? _____

Who is in charge of the finances? _____

Social History

The more we know about your relative, the better we will be able to interact with him/her.

Occupation(s): _____

Date of Retirement: _____ Level of Education: _____

Birthplace: _____

Hobbies/Special Interests:

Clubs or Organizations:

Life Accomplishments/ Special Achievements:

Places Traveled/ Favorite Vacation Spots:

Favorite Food/Snacks: _____

Favorite Color: _____

Favorite Activity: _____

Other Important Information to help us better know your loved one:

Home environment information:

Pets? Yes No

Names & Types: _____

Does your relative have his/her own room? Yes No Smokers in the home? Yes No

Children in the home? Yes No Names & Ages

Other information about the home environment?

Other

Would you consider him or her to be low income? Yes No

What kind of support do you have as a caregiver? (family, support groups, in home care etc.)

Are you a caregiver for more than one person? Yes No If yes, please explain: _____

Other Memory Loss Questions, if relevant:

1. How long has memory loss been evident? _____

2. Does the person acknowledge a diagnosis of Alzheimer's or Dementia? _____

3. How does the person respond to discussion about his/her memory problem? _____

4. Is he/she interested in learning more about memory loss? _____

Physical Health	Good	Moderate	Poor	Notes:
Oriented to Person/ Time / Place				
Mobility				
Vision				
Hearing				
Oral Status				
Lower Extremities				
Upper Extremities				
Nutrition/Diet				
Weight				
Balance				

Cognitive Health	Good	Moderate	Poor	Notes:
Short Term Memory				
Long Term Memory				
Attention/ Focus				
Recognition of Objects				
Spatial Abilities				

Communication Skills	Good	Moderate	Poor	Notes:
Comprehension				
Ability to Verbalize				

Questions or Comments. What do you think Silver Club staff should know about him/her?

Signature: _____ **Date:** _____

Silver Club Participant Financial Information

To be considered for the sliding scale, this form must be completed. You may choose to skip this form and pay \$25/hour.

Above 300% federal poverty level not eligible for sliding scale

Max Monthly Income-

1 person household- \$3390

2 person household- \$4509

Participant Name: _____ **Date:** _____

Name of person(s) completing this form: _____

We will pay \$25/ hour and skip this form

Gross Monthly Income:

(social security, VA benefits, pensions, alimony, estate or trust funds, interest income, employment, SSI)

Participant: \$ _____ .00 **Spouse:** \$ _____ .00

Total Household Income (participant + spouse) \$ _____ .00

Assets (optional- not included in calculation of total income for cost sharing purposes):

(savings, checking, equity/real estate, stock, CD, IRA, money market, cash value life insurance)

Participant: \$ _____ .00 **Spouse:** \$ _____ .00

Total Assets (participant + spouse) \$ _____ .00

Current Monthly Household Expenses:

(rent, heat, car, electricity, insurance, property tax, credit cards, water/sewage, food, life insurance, other)

