Elder Day Stay

Intake Information

PARTICIPANT INFORMATION		
Name:		Preferred Name:
Date of Birth:	SSN:	Phone:
Home Address:		
City:	State:	ZIP Code:
Marital Status:	Is the participant a veteran?:	
LIVING SITUATION		
How many adults living in the home?:	How many children living in the home?:	
Estimated Individual Income: $ /Month	Estimated Household Income: $ /Month	
CAREGIVER/REPRESENTATIVE INFORMATION		
1 Name:		Relationship:
Phone:	Phone:	Email:
Home Address: *(if different from the participant)*		
City:	State:	ZIP Code:
OTHER CONTACTS		
2 Name:	**3** Name:	
Relationship:	Relationship:	
Primary Phone:	Primary Phone:	
Secondary Phone:	Secondary Phone:	
HEALTHCARE PROVIDERS		
Primary Care Physician:	Type:	Phone:
	Last Visit:	*Next Scheduled Visit:*
Primary Insurance:	Policy Number:	

PERMISSIONS	
I ______________________________ confirm legal authority to enroll this participant in the Elder Day Stay program. *Caregiver/Representative* As representative of a participant in this program, I authorized Elder Care Services to:	
Initial:	…release photos of ___________________________for promotional/presentation purposes such as Facebook. Please notify director if you have concerns about the participant having their photo taken.
Initial:	…share or request medical/personal information from health care providers and community partners as relevant to the participants enrollment in this program or additional services.
Initial:	…provide necessary emergency medical care and if deemed necessary, coordinate for the participant to be transported to the hospital of your choice. *(choose one)* **Capital Regional Medical Center** **or** **Tallahassee Memorial Hospital** This treatment/hospital release is effective from today until termination of services.

PARTICIPANT:	CAREGIVER/REPRESENTATIVE:	DATE:

PLANNED ATTENDANCE		
Monday Tuesday Wednesday Thursday Friday Please notify staff if you plan to miss a scheduled day.		
PAYMENT		
Name of Participant:		
Name of Responsible Party *(if applicable):*		
Responsible for Payment: Private Pay Grant Medicaid LTC Other:		
Billing Address *(if different):*		
City:	State:	ZIP Code:
Primary phone:	Other Phone:	Email:
PAYMENT AGREEMENT		
Private pay fee for day care is $60.00/daily. Payment is due 30 days following receipt of invoice. By signing, the responsible party confirms legal authority to perform this agreement and agrees to pay invoices in full **or** abide by hours/days approved in the authorization. Accounts more than 30 days past due may result in an interruption of services.		Signature:

AUTOMATIC PAYMENT (OPTIONAL)

Elder Care Services, Inc. offers the opportunity to pay for services through automatic withdraw. **Skip this section if private payment is not applicable or if you do not wish to enroll in auto pay.**

Please withdraw from my **Bank Account** (Select Type): Checking OR Savings	OR	Please charge my **Credit Card** (Select Type): Visa MasterCard American Express
Withdrawn on or after the 15th of the Month following service.		**Charged on or after the 15th of the Month following service.**
Financial Institution:		Card Number:
Routing Number:		Expiration Date:
Please attach voided check to packet.		CVV Security Code:

Account/Card Holder Name:		
Billing Address: *(if applicable)*		
City:	State:	ZIP Code:

AUTOMATIC PAYMENT AGREEMENT

I hereby authorize Elder Care Services, Inc. (Tax ID Number: 59-1426079) to initiate credit card or debit entries and adjustments for any error to the account at the financial institution named above. This authority is to remain in full and until ECS has received written notification from me of its termination in such time and in such manner as to afford ECS and the financial institution named above a reasonable opportunity to act on it. **Please notify staff of any changes.**

PARTICIPANT:	CAREGIVER/REPRESENTATIVE:	DIRECTOR:	DATE:

Elder Day Stay

Representative/Caregiver Designation

HEALTHCARE AGENT DESCRIPTION	
	Self, I am the participant.
	Health Care Proxy per Florida Statute 765.401 in the following order of priority: ____ participant's spouse; ____Adult child of the participant, or ____Representing a majority of the adult children who are reasonably available for consultation; ____Parent of the participant; ____Adult sibling of the participant or, ____Representing a majority of the adult siblings who are reasonably available for consultation; ____Adult relative of the participant who has exhibited special care and concern for the participant and who has maintained regular contact with the participant and who is familiar with the participant's activities, health, and religious or moral beliefs; ____Close friend of the participant ____A clinical social worker licensed pursuant to chapter 491
	Health Care Surrogate per health care surrogate designation dated ___________
	Agent under the **Durable Power of Attorney** dated ____________
	Guardian of the Person/Guardian of the Property, or both, with Letters of Guardianship

The undersigned agent hereby affirms that the authority, as indicated above, is in force and has not been revoked by ______________________________ or revoked or suspended by any Court, to the best information and knowledge of the undersigned agent. The undersigned agent agrees to provide a true and correct copy of the agent's authority to act for the participant, if applicable, i.e. a copy of the Health Care Surrogate Designation, Durable Power of Attorney, and/or Letters of Guardianship. If the undersigned is a court-appointed Guardian for the participant, the Guardian acknowledges that a court order approving this agreement with Elder Care Services must be obtained and will be provided promptly to Elder Care Services.

CAREGIVER/REPRESENTATIVE:	DATE:

Social History

This information is used to create a personalized plan of care for each participant.

Participant Preferred Name ____
Education/Work History ____
____
Military Service ____
Cultural Considerations ____
Significant Family Members or Close Friends ____
Activities or areas of interest ____
____
Religious Participation, Volunteering, Organizations or Clubs __________________________
____
How does the participant deal with conflict?____
____
Describe the participant's personality during earlier life. Has it changed with age?_____________
____
Describe the participant's daily routine (Including any services they may currently receive)
____
____
Why did you select Elder Day Stay?____
____
What is the main goal of attending Elder Day Stay? (i.e. reduce risk of isolation, safety, exercise, etc.)____
____
What are some of the participant's strengths and challenges? ______________________________
____
____
Does the participant need assistance when using the restroom or utilize any protective undergarments like pads or pull-ups? ____
____
Are there any additional services/items you may need? (i.e. medical equipment, counseling, in-home services, etc.) ____
____

Elder Day Stay

Physician Approval for Adult Day Care Services

PARTICIPANT INFORMATION		
Name:		Today's Date:
Date of Birth:	Last 4 SSN:	Date of Last Exam:

DIAGNOSIS/BRIEF HEALTH HISTORY	
☐ Food/Medication Allergies:	
☐ Anemia	☐ Kidney problems or renal disease Dialysis?:
☐ Arthritis, Type:	☐ Liver problems
☐ Bed sore(s) (Decubitus), location:	☐ Lung problems, Type:
☐ Blood pressure ☐ High ☐ Low	☐ Paralysis: ☐ Full ☐ Partial ☐ Local, site:
☐ Broken bones/fractures, location:	☐ Seizure disorder, type & frequency:
☐ Cancer, Type:	☐ Stroke/CVA
☐ Cholesterol: ☐ High ☐ Low	☐ Thyroid problems/Graves/Myxedema ☐ Hyper ☐ Hypo
☐ Dehydration	☐ Ulcer(s), site:
☐ Diabetes, Type: Insulin-Dependent?:	☐ Tumor(s), site:
☐ Gallbladder: ☐ Problems ☐ Removal	☐ Urinary Tract Infection (UTI) ☐ Reoccurring ☐ Past
☐ Incontinence of bladder or bowels Level:	☐ Other:

TRANSMITTABLE DISEASE/INFECTION		
☐ Human Immunodeficiency Virus (HIV) (Note: may be permitted to attend if otherwise eligible)	**Tuberculosis Screening Required** **Less than 45 days before attending the center & annually.**	
☐ Human Papilloma Virus (HPV)/Genital warts	☐ **Tuberculin skin test (TST)** **or** ☐ **Chest X-Ray**	
☐ Hepatitis, Type:	**Date Administered:**	**Result:**
☐ Shingles	**Administered by:**	
☐ Syphilis	**Signature:**	

TRANSMITTABLE DISEASE STATEMENT		
☐ **Yes,** this patient appears to be free of any communicable disease/infection at this time and is cleared to socialize in a group setting. **Notify Elder Day Stay of changes by phone at: 850-222-4208 or fax 850-222-0330.** List limitations, if any: ☐ **No,** attendance is not recommended at this time.	Physician Name: Physician Signature:	Date:

IMMUNIZATIONS	
Annual immunizations are not required but are highly recommended to prevent illness spread in our group setting.	
COVID Vaccine: Dose One: Dose Two:	Influenza Vaccine:

MOBILITY	FALL RISK
□ Independent □ Cane □ Walker □ Wheelchair □ Other:	□ Low Fall Risk □ Moderate Fall Risk □ High Fall Risk □ Recent falls: □ Difficult with balance or dizziness?:
SENSORY	**DIETARY RESTRICTIONS**
□ Hearing Impaired □ Visually Impaired □ Hearing Aid □ Wears Glasses □ Deaf □ Blind	□ Low Sugar □ Pureed □ Low Salt □ No Food by mouth (NPO) □ Thickened Liquids □ Other ________________ Type: ___________
COGNITIVE HEALTH	**MENTAL HEALTH**
□ Mild cognitive impairment □ Alzheimer's □ Parkinson's □ Other:	□ Depression □ Anxiety □ Schizophrenia □ Other:

MEDICAL SERVICES ORDERED DURING ATTENDANCE

Our clinical staff is available to provide some medical services/monitoring between **10:00 am and 2:00 pm**. Medications should be administered at home, when possible. All medications must be stored in their original container, cannot be expired, and instructions on the label must match instructions on this order. Attach additional sheet if neeeded.

□ MEDICATIONS TO BE ADMINISTERED AT ELDER DAY STAY BY NURSE

MEDICATION	ROUTE	DOSAGE	TIME

□ OVER THE COUNTER MEDICATIONS (AS NEEDED)

MEDICATION	APPROVAL	DOSAGE	FREQUENCY
ACETAMINOPHEN	□ Yes □ No		
LOPERAMIDE (IMODIUM)	□ Yes □ No		
OTHER:	□ Yes □ No		

□ BLOOD SUGAR CHECK

FREQUENCY:	PARAMETERS:

□ OTHER MEDICAL REQUIREMENT WHILE ATTENDING (Such as oxygen assistance, oxygen level monitoring, or weight monitoring)

INSTRUCTIONS:

APPROVAL TO RENDER MEDICAL SERVICES AS AUTHORIZED ABOVE

PHYSICIAN NAME:	ADDRESS:
SIGNATURE:	**DATE:**

Please attach a full medication list for our records. If a DNR order is in place submit a copy for posting.

Elder Day Stay

Policy and Procedure Guide

ELDER CARE SERVICES, INC.

Program Overview

Elder Day Stay (EDS) is one of five programs offered by Elder Care Services, Inc. EDS provides protective supervision and activities in a pleasant home-like environment. Activities include crafts, discussion groups, exercise, games, movies, and music. These activities help participants remain as active as possible. If the center is at capacity, eligible potential participants will be placed on a waiting list. If an individual is determined inappropriate for this program, staff can provide referrals to other possible options in the community.

Eligibility

- Age 60 or older or experiencing symptoms of dementia
- Able to stand and transfer with minimal assistance
- Appropriate to attend as determined by **health/physical form** and **TB screening**

Behavior Standards

EDS staff is committed to maintaining a nurturing place for all participants and staff. Extensive disruptive behaviors are not appropriate for the daycare environment. The eligibility of participants who are prone to behavior challenges will be made on an individual basis by the Director. Verbal or physical abuse may result in temporary or permanent termination from the program. If behavioral intervention or medication adjustments can eliminate problem behaviors, the participant may be permitted to attend on a conditional basis.

Hygienic Standards

EDS participants should maintain good hygiene. Good hygiene includes appropriate personal care or allowing staff to assist with personal care, good oral hygiene, and clean clothing. In recurring cases of poor hygiene, staff will work with the participant and caregivers to develop a plan to improve hygiene. Participants who appear to be experiencing a pest concern (i.e. bed bugs, fleas, or lice) will require clearance from the Director before they may return.

Personal Care Guidelines

Caregivers are responsible for providing extra clothing, briefs/pull-ups, and pads as needed. EDS will supply wet-wipes. Trained EDS staff are always available to assist with restroom reminders and personal care. The Director and nursing staff will evaluate participants with extensive toileting needs for appropriateness.

Program Cost

The fee for service is $60.00 per day. Participants must be enrolled on the state-funded program waitlists to receive financial assistance. To be added to the waitlists, contact the Elder Helpline (800) 963-5337 to complete the telephone assessment. If the participant receives financial assistance or Medicaid Long Term Care, the participant is responsible for co-payments and adhering to authorization guidelines. Services outside of authorization may be billed to the participant.

Hours

EDS is open to participants from 7:30 am - 5:30 pm, Monday through Friday. A late fee may be assessed if the participant is repeatedly not picked up by 5:30 pm. EDS will be closed in observance of the following holidays: New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Juneteenth, Labor Day, Veteran's Day, Thanksgiving and the day after, Christmas Eve and Christmas Day, and New Year's Eve. Caregivers will be informed of closure for any other reason in advance, whenever possible.

Transportation

Transportation is provided or coordinated by caregivers. Participants are expected to have reliable transportation available to The Director can assist with the coordination of transportation if needed. In the event of a medical emergency, EDS will contact Emergency Medical Services. EMS will transport the participant to the preferred hospital requested in the intake packet.

Pick Up/Drop Off Procedure

The front ramp area is used for drop off and pick up only. Caregivers must walk the participant to and from the vehicle if the participant requires assistance. Please notify the Director if special accommodations are needed.

Attendance
Participants should plan to attend as scheduled. Advanced notice of absences should be provided to allow for adjustments to meal and staffing patterns.

Illness or Suspected Illness
Participants may not attend when ill or suspected of being contagious to prevent the dangerous spread of illness. Any participant who is diagnosed with a communicable disease/infection is unable to attend until deemed non-infectious. Participants who have a temperature or appear to be sick must be picked up within 2 hours of notification. Participants must have reliable contacts and transportation available on short notice.

- The participant must be free from symptoms such as diarrhea, vomiting, and fever (without the use of symptom-controlling medication) ***for at least 24-hours before returning to the center****. Special precautions may be necessary under some circimstances such as a pandemic.*
- If symptoms in question, (i.e. coughing, runny nose, occasional diarrhea) are determined to be the result of a non-contagious condition, the participant can return with written documentation from their physician. Though if a contagious condition cannot be ruled out, the participant may not attend until no symptoms are present.

Medication

- Medication (including OTC) can be administered between 10:00 am- 2:00 pm with a written Physician's order.
- Medication must be in the original bottle, not expired, and instructions must match written order.
- Prior approval is required for participants to bring medications to self-administer.

General Wellness
EDS recommends participants discuss the benefits of receiving vaccines, including the annual flu vaccine, with their primary care doctor annually. Our Registered nurse is available to discuss medication management. Additionally, we have a registered Dietitian available to discuss nutritional needs. Our multidisciplinary team will work with the participant and caregiver to update this plan as needed or at least quarterly. Please reach out to the Director or Assistant Director if you would like additional support or have items you would like to have included in the participant's care plan.

Nutrition
EDS provides a balanced breakfast (served until 9:15 daily), lunch, and a snack to participants daily. Participants who require or prefer to have alternative meal items must provide them. Food brought from home should be managed by staff members only. For the health and safety of all participants, candy should not be brought into the center.

Emergency Operations
If evacuation from the building is required, participants will relocate to the Tallahassee Senior Center, 1400 North Monroe Street, as designated in our emergency plan. Refer to the Emergency Operating Procedure posted in the lobby. Updated information on evacuation shelters will be available at the beginning of each hurricane season. It is recommended all participants enroll in the Special Needs Registry by visiting: snr.floridadisaster.org.

Personal Belongings
We recommend purses, wallets, jewelry, blankets and/or cups be left at home. Participants will have access to a cubby in the front of the building and a personal bin in the nurse's office if needed. Clean blankets will be provided when available. Alcohol and tobacco products are not permitted in the center. Please write the participant's name or initials on all clothing articles, especially if they experience incontinence.

Program Termination
These policies and standards are in place to ensure a healthy, pleasant and stimulating environment for all EDS participants and staff. When a participant or caregiver does not adhere to these standards, a conference will be scheduled to discuss options**.** In the event it is determined EDS can no longer meet the needs of the participant and caregiver, the Director will recommend other community resources. A 10-day termination notice will be given if possible. If the participant poses a threat to others, immediate termination may be necessary. EDS will donate uncollected personal items after 30 days of termination.

Agency Policy 6.02

1. Elder Care Services, Inc. (ECS) will assist participants in resolving any grievance or complaint that may arise concerning the receipt or denial of service or the application of a policy or procedure. If a participant has a grievance or complaint not related to termination, suspension or reduction in services, he/she should first present it directly to the program manager, administrative staff or other directly involved employee for solution or explanation.

2. If the participant is to be the recipient of adverse action deemed termination, suspension or reduction in service related to a state or federal program for the elderly, the following procedures shall apply:
   a. Written notice shall be provided to the recipient not less than ten (10) calendar days prior to the effective date of the adverse action, unless the health or safety of the recipient is endangered if action is not taken immediately.
   b. Services shall not be reduced or terminated nor other adverse action taken during the 10-day period.
   c. The notice to the participant shall include an explanation of the recipient's right to a grievance review, if requested in writing and delivered within ten (10) calendar days of the date the notice is postmarked, a statement of what action is being taken, the reasons for the intended action, the right after the grievance review for further appeal and the right to seek redress through the courts, if applicable.
   d. If a review is requested, current services shall continue until a final decision is made by ECS regarding the adverse action.
   e. The recipient shall be advised that he or she may represent himself/herself or use legal counsel, a relative, a friend or other qualified representative in the review proceedings.

3. Should the participant not receive total satisfaction, he/she may file a written grievance for a hearing with the President/CEO.
   a. The written grievance/complaint should include the name, address and telephone number of the participant, date, time and place of the incident, and all details of the incident leading to the grievance/complaint. Mail complaint to: Elder Care Services, Inc.: President/CEO 2518 West Tennessee Street, Tallahassee, FL 32304

4. The President/CEO will have seven (7) calendar days from the date of receipt of the grievance/complaint to respond in writing to the participant. The President/CEO will send a notice to the participant that will contain the following:
   a. A statement of what action is intended to be taken
   b. The reasons for intended action
   c. The specific law, rule or regulation, or change of law that requires the action

5. If the participant wishes to appeal the President/CEO's decision or to request a review by the Board of Directors regarding termination, suspension or reduction in services in a State or Federal Program, the request shall be made in writing to: Elder Care Services, Inc.: Board of Directors 2518 West Tennessee Street, Tallahassee, FL 32304

Assistance with writing, submitting and delivering the request for review will be offered and made available to the individual.

6. Within seven (7) days of the receipt of a request for review, the President/CEO will acknowledge receipt of the request and will provide notice of:

   a. The time and place schedule for the review at a reasonable time, date and place with one or more of the Board of Directors not involved in the issue or decision acting as an impartial reviewer.
   b. The opportunity to examine, at a reasonable time before the review, the individual's own case record, and to copy such record at no cost to the individual.
   c. The opportunity to informally present arguments, evidence, or witnesses without undue interference at a reasonable time before or during the review.

d. The availability of assistance for any accommodations required under the Americans with Disabilities Act, assistance, if needed, in order to attend the review, and assurance that no adverse action will be taken until all appeal rights have been exhausted.
e. The stopping of all intended negative actions if requested, until all appeals are exhausted. The participant may be responsible for part or all of the cost of continued services should the agency prevail upon appeal.

7. The Secretary of the Corporation will provide written notification to the requester within seven (7) calendar days after the grievance review of:

a. The decision of the Board or designated Board Member stating the reasons therefore in detail.
b. The effect the decision has on current benefits, if favorable, or the circumstances regarding continuation of current benefits until all appeals are exhausted.

8. If the grievance/complaint has not been handled to the satisfaction of the participant after a hearing with the Board of Directors or Board Designee, the participant may contact the Area Agency on Aging for North Florida, or other appropriate agency, in writing to request a hearing or may file a grievance with the Florida Bar regarding a legal assistance provider. Assistance will be available with writing, submitting and delivering any appeal.

9. Long term care applicants or participants have a right to a fair hearing at any point in the above process through the Department of Children and Families Office of Appeal Hearings, Building 5, Room 203, 1317 Winewood Blvd., Tallahassee, FL 32399-0700 (Telephone: 850-455-1429). The individual or authorized representative may request a hearing within 90 days of the decision affecting receipt of Medicaid or Long Term Care services.

Abuse and Fraud Reporting Information

To report expected abuse, neglect, or exploitation of a vulnerable population, please call toll-free:

1-800-962-2873

TTY: 1-800-955-8771

Elder Helpline Waitlists

To enroll on the waitlist for assistance paying for services please call Advantage Aging Solutions **850-488-0055** and complete phone screening. Mention you are interested in day care services.

In accordance with Federal law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity. To file a program discrimination complaint, a complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form, which can be obtained online at www.usda.gov/sites/default/files/documents/usda-programdiscrimination-complaint-form.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or fax: (833) 256-1665 or (202) 690-7442; email: program.intake@usda.gov.

This institution is an equal opportunity provider and employer

AHCA#9049 Elder Day Stay

Elder Day Stay

Covid Release Statement

RELEASE STATEMENT
I , ______________________________ request ___________________________ be permitted to return as *Caregiver/Representative* *Participant* an Elder Day Stay participant. I understand and acknowledge that by choosing to return to Elder Day Stay, the participant may be at a higher risk of being exposed to the COVID-19. I agree to follow the Center for Disease Control, local health district guidelines, as well as Elder Day Stay's policies to protect my household and other participants against COVID-19. I acknowledge that Elder Care Services, Inc. ("ECS"), is taking steps to ensure the safety of participants and staff by limiting capacity and sanitizing spaces. As a participant, I understand I will be screened daily, asked to wear a properly fitted mask, follow social distancing guidelines, regularly wash hands and use hand sanitizer. I understand that I will likely be asked to get tested for COVID-19 should an exposure occur. I understand that failure to follow guidelines may result in a suspension of participation at Elder Day Stay. Elder Care Services reserves the right to limit or suspend any participants' attendance to preserve the safety of other participants and staff. By signing this form, I confirm my legal authority to execute this document and release ECS, its Board, its Board members, administrators, directors, officers, employees, agents, assigns, and volunteers ("released parties") from and against any and all claims, demands, actions, complaints, suits or other forms of liability that any of them may sustain arising out of (a) Participant's return to Elder Day Stay, (b) failure to comply with the measures imposed by ECS, or (c) a failure to comply with local, state, and federal laws and ECS' policies and procedures.

ACKNOWLEDGEMENTS	
Initials:	I understand the responsibilities outlined in this document and agree to take steps to protect my household and other participants by following these guidelines.
Initials:	I release Elder Care Services Inc. and /or their staff members, from liability for any potential exposure to COVID-19 or other communicable diseases the participant may encounter from staff or other participants.
Initials:	I understand the risks, and I am making an informed decision to request the participant return to Elder Day Stay.

Caregiver/Representative	*Staff Signature/Witness*	*Date:*

Elder Day Stay

COVID Screening Questionnaire

COVID-19 SCREENING QUESTIONNAIRE			
Participant:			**Date:** / **Temperature:**
	No	**Yes**	**Details**
Have you (participant) traveled in/out of the immediate county area in the past two weeks?			Where?
Have you (participant) attended any gatherings of five or more people in the last two weeks?			
Have you (participant) or anyone in your home experienced any COVID symptoms in the past two weeks?			_______ Fever or chills _______ Cough _______ Shortness of breath _______ Difficulty breathing _______ Fatigue _______ Muscle or body aches _______ Headache _______ New loss of taste or smell _______ Sore throat _______ Congestion or runny nose _______ Nausea or vomiting _______ Diarrhea
Have you been in contact with someone who has -or- is under investigation for COVID-19?			
Have you (participant) or anyone in your home been tested for COVID-19?			Results? Date of test:
Have you been vaccinated for COVID-19?			Date(s) of vaccine:

ATTESTATION		
I attest the answers I have provided are true to my best knowledge. I will report any changes to these responses to Elder Day Stay as soon as possible.		
Caregiver/Representative	*Staff Signature/Witness*	*Date:*