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EASTERN OKLAHOMA COUNTY TECHNOLOGY CENTER
ADULT DAY SERVICES
4601 N CHOCTAW RD, CHOCTAW, OK 73020 • 405.390.4400

ADMISSION REQUIREMENTS

- EOC Adult Day Center (ADC) will not enroll any person whose needs exceed the capability of the program. ADC does not provide skilled nursing services or one on one care.
- Acceptance into the ADC is provisional and there will be a 10-day trial period to see if the program is appropriate for ones needs. If participant exhibits behavior that interferes with the operation of the ADC, I understand he/she will be discharged from the program.
- Admission will not be determined by race, color, religion, gender, national origin, marital status, and will not affect the decision to admit for services.
- No Alcohol/Tobacco/Drug use or paraphernalia is allowed on the premises of ADC or on the EOC Technology campus.
- Participant must be free of any infectious communicable disease, i.e., HIV, TB, Hepatitis or MRSA (Staph Infection).
- Participant must be able to assist with transfers and has demonstrated adequate gait and safety measures.
- Participant must be able to feed self with very little assistance from staff.
- Participant must be able to swallow small cut up pieces of food without difficulty.
- Participant must be continent of stool and in control of bowel function.
- If participant is incontinent of urine, they agree to wear Attends, pads or other effective undergarments.
- Participant must be able to sit upright for intermittent times at the facility.
- Participant must have seizures maintained and under control.
- Participant must be able to self administer their own insulin and together with their Physician, have their condition managed while at the ADC.
- Participant's Vital signs will be stable upon admission
- Participant cannot be physically abusive to others, nor exhibit repeated or uncontrolled verbal abuse, or exhibit any sexually inappropriate behavior or behavior that interferes with the operation of the program.
- Participant must schedule with the Program Nurse an assessment to evaluate medical needs.
- When enrolling, a Physical Examination form and a Physician Medication Order form must be completed before enrollment in the ADC and will be re-done yearly.
- Participant will provide a yearly update to the Emergency Contact Form.
- A licensed Dietitian will review the care plan and dietary needs will be addressed, if needed.

*** The above admission requirements are written in compliance with State Regulation, Title 310:605-13-2 from the Oklahoma State Department of Health.**

I have read these admission requirements, and to my knowledge, our participant currently meets the admission criteria of the EOC Adult Day Center and will be able to participate in the program.

_____ _____

Participant/Caregiver/Guardian Date

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ADDENDUM TO ADMISSION REQUIREMENTS

All school personnel are to follow applicable state and federal guidance for COVID-19. This includes administrative staff, certified and support personnel and all participants. Applicable guidance includes written guidelines from the Centers for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), the Oklahoma State Department of Health (OSDH), Oklahoma Department of Commerce, that from any other agency, board or commission, state or feral regulations or applicable executive order.

The following mandated guidelines are in place to assist in reducing the spread of COVID-19 based on above listed entities' practices for the health and welfare of the EOC ADC community.

***Mandated Guidelines:**

- Stay home if tested positive for COVID-19.
- Stay home if exhibiting symptoms of COVID-19.
- Stay home if close contact with someone testing positive for COVID-19.
- Face Coverings: A face covering (mask or shield) is **required** in campus building at all times. *A face covering is not required in offices, classrooms or other areas when alone. A face covering is not required while eating with social distancing recommended.*
- Temperature Checks: All students and staff will be subject to a temperature screening/hand sanitizing upon entering the building. *Any participant or staff member with a temperature exceeding 100.4 degrees will not be allowed to enter the building. Participants will be sent home or quarantined until caregiver pick up.*

I have read and understand the above-mentioned guidelines:

Name: _____ Date: _____

Infection Preventionist: _____ Date: _____

**http://www.eoctech.edu/wp-content/uploads/2020/08/COVID-19-Operations_Public_08-07-2020.pdf (Pg 4)*

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: _____SS # _____

DOB ____/____/_____ Male _____ Female _____

The purpose of this disclosure:_____

This authorizes the below named physician, hospital or other organization, agency or person having medical, health, social or economic records, data or information concerning the above identifies participant to furnish such records as may be required on my behalf by the *EOC Tech Adult Day Center (ADC)*
This also authorizes the *ADC* to furnish medical, health, social or economic records, data, or information concerning the above identified applicant to the below named physician, hospital or other organization, agency, or person having need for such information.

The participant understands that this authorization is needed to provide *ADC* for coordination of medical, health, social or other related services. It is understood that information thus obtained by *ADC* will be treated as confidential information.

- I understand that I may ask questions, consult with anyone and review these records before I sign this form.
- This form will only be valid for one year in which a new authorization for release of medical information will be required.
- The facility, its employees and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____
(Participant/Spouse/Guardian)

Program Staff: _____ Date: _____

(Meets HIPAA Requirements)

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CONFIDENTIALITY GUIDELINES

1. All participant records will be kept and treated with strict confidentiality in a locked file cabinet.

2. All EOC Adult Day Center (ADC) staff will sign confidentiality agreements as an employment requirement.

3. Participant records will be available only to the ADC staff or other authorized persons (ie: State or federal auditors).

4. All Volunteers are supervised and are required to maintain confidentiality guidelines when interacting with participants or documenting in the interdisciplinary progress notes when required.

5. The EOC Adult Day Services is a teaching facility and students from several different classes and schools visit our facility regularly. All students are supervised and are required to maintain confidentiality guidelines when interacting with participants.

6. The participant, or their representative, must sign authorization for release of information to and from the E.O.C. Adult Day Services, before any information will be released or requested.

7. Participants are not discussed in the presence of other participants or any unauthorized persons.

8. No information concerning individual clients will be displayed in areas accessible to the public without consent.

10. Forms or documents containing participant information will be maintained in the ADC for at least five (5) years following termination of enrollment by the participant and then disposed of appropriately as confidential information.

I have read and accept the E.O.C. Adult Day Services Confidentiality Guidelines.

_____ _____

Participant/Caregiver/Employee/Volunteer Date
(Meets HIPAA Requirements)

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ADDENDUM TO CONTRACT FOR SERVICES

Our center's hours of operation have temporarily been changed **from** 7:30 AM - 5:30 PM **to** 7:30 AM - 3:30 PM. All late charges still apply.

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CONTRACT FOR SERVICES

Participant _____Phone _____

Address _____

Person responsible for payment **if different than above**:

Name _____ Relationship _____ Phone _____

Address_____

Fee for Services
I am entering into an agreement of participation with the E.O.C. Senior Adult Day Services in Choctaw, OK. I have been informed that the private pay fee for services is ***$65 per six-hour day.*** An hourly rate of ***$10.83*** is paid for attendance of less than 6 hours a day. This fee includes the cost of meal service.

Department of Human Services, Veterans Administration, and Advantage Waiver:
Fee for services is determined by the agency. DHS qualifies individuals based on their income. Co-payment amounts are determined by the DHS county office after an application is submitted.

I understand that the E.O.C. Senior Adult Day Services relies on participant fees to cover the costs of care and services. A bill will be mailed at the beginning of the month for the previous month's services or upon discontinuation of services. Checks should be made out to **E.O.C. Technology Center**. They may be mailed to:

E.O.C. Technology Center
Attn: Senior Adult Day Services
4601 N. Choctaw Rd.
Choctaw, OK 73020

Payments are due by the 15th of each month. A late fee of $10.00 per week will be charged for balances not paid on time. A fee of $20.00 will be applied for returned checks. We also accept credit cards.

Cancelled Meals/Transportation
When you contract with us for services, we secure meals, staff, and transportation, etc., for the participants. The participant or caregiver will be responsible for notifying the SADS before 8:30 a.m. in cases of unscheduled absences (illness, emergencies, etc.). Notification must be made by noon the day prior to a scheduled absence (doctor's appointment, vacation, etc.). Additional charges for meals and transportation not cancelled in a timely manner will be billed as follows: $5.00 for uncancelled meals.

Overtime Fees
The *SADS* is open 7:30 a.m. - 5:30 p.m. I also understand that an additional fee of $10.00 for any portion of the first fifteen minutes and $5.00 for each additional five-minute period thereafter will be charged to participants who depart after the close of the Center at 5:30 p.m.

The Department of Human services, the Veterans Administration, and Advantage Waiver do not cover delinquent fees, overtime charges, or additional charges for uncancelled meals or transportation.

_____ _____
Person Responsible for Payment Date

_____ _____
Program Director Date

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EMERGENCY CONTACT INFORMATION

_____
Date

Participant Name: _____
Last First M

Participant SSN: _____ Participants D.O.B:_____

Participant Address: _____

Caregiver/Guardian Name & Address: _____

Care Giver/Guardian Phone: _____

Primary Physician Name: _____ Phone: _____

Hospital Preference: _____

Medical Diagnosis: _____

Allergies: _____

In Case of Emergency Notify:

_____
Name/Relationship Work Phone Home Phone Pager/Cell Phone

_____ _____
Name/Relationship Work Phone Home Phone Pager/Cell Phone

Insurance Coverage:

Medicare: _____Medicaid: _____ Supplement: _____Other _____

Are any of the following in effect? If so, please provide a copy for our records.
Power of Attorney: Yes/No Legal Guardianship: Yes/No
Living Will: Yes/No DNR: Yes/No

IN CASE OF A MEDICAL EMERGENCY I AUTHORIZE THE ADULT DAY CENTER TO SECURE AND OBTAIN PROPER MEDICAL TREATMENT ON MY BEHALF. IF IN NEED OF AN EMERGENCY VEHICLE, I GIVE THE ADC PERMISSION TO USE MIDWEST CITY HOSPITAL AMBULANCE SERVICE.

PARTICIPANT/CAREGIVER SIGNATURE: _____

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GENERAL RELEASE OF LIABILITY

I would like to attend the EOC Technology Adult Day Center and participate in the daily program.

My participation is voluntary and I release and agree to hold harmless the EOC Technology Adult Day Center, its employees, volunteers, and agents from any and all liability and responsibility (unless proximately caused by the willful misconduct of any of the above mentioned) for or relating to any illness, accident, or other event which may occur while I am a participant in the program.

_____ _____

Participant Name Date

_____ _____

Caregiver/Guardian Date

_____ _____

Program Staff Date

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MEDICATION ADMINISTRATION PROCEDURES

1. Only a licensed or certified staff member will give any and all medications, including over-the-counter and prescription, during attendance at *EOC Tech Adult Day Center (ADC).*

2. Medication brought to the facility must be in a pharmacy bottle with proper pharmacy label or in the original bottle if a non-prescription medication. Medicine bottle label must match the doctor's orders given to facility.

3. The ADC must have a **physician's medication order** completed by the doctor for all medications to be given at the facility.

4. If participant is discharged, the medicine must be taken home upon discharge.

5. If participant stops coming to the *ADC*, we will send one (1) letter home advising the family to pick up all medications. If medication is still on site one (1) week after letter has been mailed, it will be destroyed, per facility policy.

6. If participant should pass away during enrollment at the ADC, all medications will be destroyed, per facility policy.

It is understood that the Senior Adult Day Services and its staff will not be responsible for any adverse effects related to the administration of any medication.

I _____, authorize the Senior Adult Day Services to administer any/all medications, to be taken by _____(participant), while attending the SADS, and agree to provide the necessary dosages of these medications.

_____ _____
Participant/Caregiver Date

_____ _____
Program Staff Date

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MEDICAL HISTORY FORM

Date: _____ SSN: _____

Participant: _____Sex: _____
Last First Middle

Medical Diagnosis:

1. _____ 2. _____ 3._____ 4._____

Primary Doctor: _____ Phone: _____

Address: _____

Secondary Doctor: _____ Phone: _____

Address: _____

Allergies:
To Medications: _____
To Foods: _____

Last seen by physician: _____

Reason for physician visit: _____

Number of doctor visits in the past year? _____

Number of days spent in the hospital in the past year?
_____

Special Diet? _____

Insurance: _____ Medicare _____ Medicaid _____ Insurance Supplement

Participant: _____ Sex: _____
Last First Middle

Current Medical Status

Weight: _____ Height: _____
Eyesight: ___ Good ___ Fair___ Poor

Glasses: ___ Yes ___ No ___ Need

Hearing: ___ Good __ Fair ___ Poor

Hearing Aid: ___ Yes (L/R/B) __ No __ Need (L/R/B)

Teeth: _____ Own _____ Edentulous _____Dentures (Upper/ Lower/Need)

Ambulation: _____ Self _____ Cane _____W/C _____ Walker
_____Stand-by Assistance

Transfer: _____ Self _____ Assist x1 _____ Assist x2
_____ Unable to bear weight

Health Conditions: (Past or Present)

	Yes	No	Comments
Alcohol/Substance Abuse			_____
Alzheimer's or other dementia			_____
Anemia/bleeding disorders			_____
Arthritis/rheumatism			_____
Bladder: Continent/Incontinent/ Dribbles			_____
Bowel: Continent/Incontinent			_____
Cancer or leukemia			_____
Cataracts			_____
Circulation problems			_____
Diabetes			_____
Difficulty with food, chewing			_____

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Participant: _____ Sex: _____
Last First Middle

	Yes	No	
Emphysema: COPD, Asthma, Bronchitis			_____
Epilepsy/Seizure Disorder			_____
Falls/Recent History of			_____
Glaucoma			_____
Heart trouble, CHF			_____
High/low blood pressure			_____
Hostile: Withdrawn/Depression			_____
Liver disease			_____
Mental Retardation			_____
Parkinson's disease			_____
Skin disorders: pressure sores, Leg ulcers, burns			_____
Stomach: intestinal disorders (Diarrhea or constipation)			_____
Stroke			_____
Thyroid Problems			_____
Tuberculosis			_____
Urinary tract disorders			_____
Wanders			_____

Other Illness's, disabilities or injuries: _____

_____

Any family history of the above-mentioned health conditions? If yes, please specify which conditions and the relationship to participant:_____

_____

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Participant: _____ Sex: _____
Last First Middle

Current medication Dosage Frequency Doctor prescribed?

_____
_____
_____
_____
_____
_____
_____

List surgeries: Place Date

_____
_____
_____
_____

List other non-surgical hospitalizations:

Reason Place Date

_____
_____
_____
_____

Are any of the following in effect?

Power of Attorney: Yes/No
Legal Guardianship: Yes/No
Living Will: Yes/No
DNR: Yes/No

If yes to any of the above legal documents please provide a copy for our records.

Program Nurse: _____ Date: _____

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Dear Participants and Caregivers,

Enclosed is the E.O.C. Technology Adult Day Center Notice of Privacy Practices. This notice of our privacy policy complies with the federally mandated HIPAA regulations (Health Insurance Portability and Accountability Act).

Each caregiver will be asked to provide written acknowledgement that they have received our Notice of Privacy Practices. You will always find our most current privacy policy on display at our Center.

We appreciate you and maintaining your privacy and confidentiality is important to us. If you have received this notice in person, please read the policy and sign. If you have received this notice by mail, please read, sign, and return it to our office as soon as possible.

Sincerely,

Vicki Wood
Program Director

NOTICE OF PRIVACY PRACTICES
(HIPAA)

You have the right to receive a notice of our privacy practices with respect to your medical and billing information. Your signature here indicates that you have received a copy of our Notice of Privacy Practices.

_____ _____
Signature of Participant or Legal Representative Date

_____ _____
E.O.C. Adult Day Services Representative Date

- **Please keep your copy of the HIPPA regulations for your medical records.**

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ARRIVAL/DEPARTURE INFORMATION & TRANSPORTATION AGREEMENT

Participant: _____

Phone # of residence where participant will be transported from: _____

Scheduled Day of Participation:

Monday	_____	Full Day	_____
Tuesday	_____	Half Day	_____
Wednesday	_____		
Thursday	_____		
Friday	_____		

Regular Arrival Time: _____ Please allow 15 min +/- to arrival time ___(int)

Regular Departure Time: _____ Please allow 15 min +/- to arrival time ___(int)

Time is subject to change with prior notice.

I authorize the E.O.C Adult Day Center staff to transport _____ from residence to the E.O.C. Adult Day Center and to field trips in a vehicle owned & maintained by the E.O.C. Technology Center.

I authorize the following individuals to transport above participant due to illness, disruptive behavior, or non-arrival of caregiver (proof of identity may be required before participant will be released):

1. Name: _____
   Phone: _____
   Relationship: _____

2. Name: _____
   Phone: _____
   Relationship: _____

_____ _____
Participant/Caregiver/Guardian Signature Date

_____ _____
Program Staff Date

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OUTING PERMISSION FORM

I, _____ give the EOC Tech Adult Day Center permission to transport _____ on outing whenever weather and conditions permit them to do so. These outings will include trips to the lake, parks, civic and cultural centers and other places of interest in and around the Choctaw and Oklahoma City metro area.

I understand that my signature authorizes blanket permission to be used in the Choctaw, Oklahoma City metro area. Any lengthy trips will require my signature on a specific document giving my permission for the trip. This document will state the whereabouts of such an outing, date and time of excursion.

The Senior Adult Day Services will see that all safety precautions and quality care will be provided to the best of their ability at all times.

I, _____ **DO NOT** give the EOC Technology Adult Day Center permission to transport _____on outings or fieldtrips due to health and safety concerns.

_____Date:_____

Parent/Caregiver/Guardian Signature

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PARTICIPANT'S RIGHTS

Each participant of the Senior Adult Day Services shall be assured of the following rights:

1) To be treated as an adult, with respect and dignity regardless of race, color or creed and to be free of interference, coercion, discrimination or reprisal.

2) To participate in a program of services and activities which promote positive attitudes regarding ones' usefulness and capabilities.

3) To participate in a program of services designed to encourage learning, growth and awareness of constructive ways to develop ones' interests and talents.

4) To maintain ones' independence to the extent that conditions and circumstances permit; and to be involved in a program of services designed to promote independence.

5) To be encouraged to attain self-determination within the adult day center setting, including the opportunity to participate in developing ones' care plan for services; to decide whether or not to participate in any given activity, and to the extent possible, in program planning and operation.

6) To be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided.

7) To have privacy and confidentiality. (HIPAA Guidelines)

8) To be free of mental and physical abuse.

9) To be free of restraint unless under physician's order as indicated on the individual plan of care.

10) To have access to telephone to make or receive calls, unless necessary restrictions are indicated in the individual care plan.

I HAVE READ THESE RIGHTS (or have had them read to me) AND UNDERSTAND EACH OF THEM.

_____ _____
Participant Signature Date

_____ _____
Caregiver/ Guardian/Staff/Student Signature Date

_____ _____
Program Staff Dated

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PHOTOGRAPH AND VOICE CONSENT

I authorize EOC Technology Adult Day Center (ADC) to take my picture by photograph, movie, videos, and/or the recording of my voice by the Senior Adult Day Services staff or persons authorized by the ADC, while participating in the ADC program. I understand my photograph, movie, videos, and/or the recording of my voice will be used on our Facebook web page.

Furthermore, I consent to and authorize the use and reproduction of any and all photographs, movies, videotapes, including prints, negatives and positives, or sound recordings which they have taken of me or arranged to have taken for publicity, education or informational purposes, without compensation to me. All prints, negatives, positives and sound recordings shall remain the sole property of the Adult Day Center.

I understand that my refusal of consent for photographs or voice release will in no way affect my eligibility for the services of the ADC or the care I receive as a participant in the ADC.

_____

Participant/Caregiver/Guardian Date

_____

Program Staff Date

(Meets HIPAA Requirements)

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TERMINATION OF SERVICES

Termination of services may occur for any of the following reasons:

1. Participant has an advanced medical, physical or psychosocial problem in which the EOC Adult Day Center (ADC) is unable to provide care and services or requires constant supervision by our staff.
2. If one becomes incontinent of stool or has lost control of bowel function.
3. Participant has a communicable disease.
4. Participant is physically and verbally abusive.
5. Participant's behavior is sexually inappropriate.
6. Participant must not need insulin administration by nursing staff during the day while at the ADC.
7. Participant has an outstanding bill of 30 days past due.
8. Abuse of services (Late in picking up participant; not ready for pick-up, etc.).
9. Non-compliance with requirements for admission & continual enrollment (ie: yearly physical from your current physician and a yearly updated emergency contact form).
10. Participant poses a danger to self or others.
11. No Alcohol/Tobacco/Controlled Dangerous Substance use or paraphernalia on the premises of EOC Adult Day Services or on EOC Technology Campus.
12. Must be able to wear a mask in all campus buildings at all times. *(http://www.eoctech.edu/wp-content/uploads/2020/08/COVID-19-Operations_Public_08-07-2020.pdf)*

Note: An incident report will be completed for any non-compliance of EOC Adult Day Service's guidelines.

DISCHARGE PROCEDURES:
Once admitted to the program and a discharge becomes necessary, the family member and/or caregiver will be notified by the Program Director or designee by letter or telephone.

STATEMENT OF UNDERSTANDING:
I have read the termination criteria for the EOC Adult Day Services program. I agree to give the Program Director full discretion in terminating services, if the participant is not in compliance with the admission requirements at the Adult Day Services.

_____ _____
Caregiver Date

_____ _____
Program Staff Date

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PLEASE KEEP FOR YOUR RECORDS

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. E.O.C. TECH SENIOR ADULT DAY CENTER'S DUTIES REGARDING PROTECTED HEALTH INFORMATION.

We are required by federal and state law to maintain the privacy of your protected health information, and in particular your "protected health information," which can be maintained, used, and disclosed in limited ways. "Protected health information" includes most kinds of "individually identifiable protected health information," that is to say, information about (1) your past, present, or future physical or mental health or condition, (2) the health care you receive, and (3) your payment for health care.

The term "use" will mean the sharing protected health information by employees and agents of E.O.C. Tech Senior Adult Day Center, while "disclosure" will mean E.O.C. Tech Senior Adult Day Center providing protected health information to other persons having a need for the information. We reserve the right to change our privacy practices and the corresponding terms of this Notice at any time. This includes, but is not limited to, the right to make changes effective for all protected health information that we maintain, including protected health information we have created or received *before* we make the changes. Before we make a significant change in our privacy practices, we will change this Notice, make it available to you upon request, and post the revised Notice in a prominent location near the entrance to our facility.

You may request a copy of our Notice at any time. For more information about our privacy practices or your rights concerning your protected health information, contact E.O.C. Tech Senior Adult Day Center's Privacy Official using the information at the end of this Notice.

II. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are authorized to use and disclose your protected health information for the following purposes:

For Treatment Purposes. Treatment purposes include the provision, coordination or management of your healthcare. We may, for example, use your protected health information to provide you with health care services, and may disclose your protected health information to your personal physician or another health care provider who is treating you.

For Payment. Payment purposes means our activities to obtain reimbursement for care provided to you. We may, for example, use protected health information in obtaining payment from a third party, such as the Veterans Administration.

For Health Care Operations. Healthcare operations are those functions needed to support our treatment, payment, and business activities in order to provide quality services. For example, your protected health information is used in evaluation the performance of our staff, in our training programs, and in demonstrating to federal and state agencies that we are in compliance with applicable laws.

In Cases of Suspected Abuse, Neglect and Other Injury. We may disclose protected health information to the appropriate governmental agency if we suspect that you have been the victim of abuse, neglect, domestic violence, or other injury.

In Health Oversight Activities. We may disclose your protected health information to federal and state agencies responsible for monitoring our compliance with applicable law and to accreditation entities to ensure that we meet appropriate standards of care.

In Legal Proceedings, Law Enforcement, and As Required By Law. We must disclose your protected health information to the extent it is the subject of a court order, an order from an administrative tribunal, subpoena for documents, discovery request, or some other lawful process with which that we have been served. Moreover, we may communicate your protected health information to law enforcement personnel if necessary to report a crime in an emergency situation.

In Public Health Activities. Under certain circumstances, we may disclose your protected health information to federal and state public health agencies whose mission is to prevent or control disease and injury.

In Situations of Serious and Immediate Threats to Health and Safety. We may disclose your protected health information when, consistent with federal or state law, we reasonably believe disclosure is necessary to prevent or lessen a serious and immediate threat to your health or safety, or that of another individual or the public-at-large.

For Specialized Government Functions. We may disclose your protected health information if needed for certain military and veterans' activities, national security matters, and intelligence activities.

In Situations Involving Military Activity. When appropriate conditions apply, we may use or disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

For Workers' Compensation Purposes. We may disclose your protected health information as authorized to comply with workers' compensation laws and similar programs.

To Personal Representatives. We may disclose your protected health information to certain persons authorized by state law to act on your behalf, including, but not limited to, a guardian, attorney-in-fact, executor or administrator.

To Individuals Involved with Your Care. Under certain circumstances, such as your incapacity, we may disclose protected health information about you to a friend or family member who is involved in your medical care or who pays for the services you receive.

Other Uses and Disclosures. Before we can use or disclose your protected health information for other purposes, we must obtain your written authorization. You or your personal representative can revoke the authorization, but the revocation must be in writing and delivered to us. In addition, the revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

II. OTHER USES AND DISCLOSURES

Health Benefits and Services. We may contact you about health-related benefits and services that may be of interest to you.

Fundraising. We may contact you to raise funds for E.O.C. Tech Senior Adult Day Center.

III. YOUR RIGHTS WITH RESPECT TO PROTECTED HEALTH INFORMATION

If you wish to exercise any of your rights discussed below, contact the Privacy Official identified below:

Access to Protected Health Information. With limited exceptions, you have the right to look at your protected health information. You must submit a written request to the Privacy Official whose name, address, and telephone number are included at the end of this Notice. We can provide you with a request form, or you may mail a request letter to the Privacy Official.

Obtain a Copy, Summary, or Explanation of Your Protected Health Information. You may request in writing a photocopy of your protected health information. We can provide you with a request form, or you may mail a request letter to the Privacy Official. We will charge a reasonable rate (i) per-page and (ii) per-hour for staff time to copy your protected health information. You will also be charged for postage if you request that the copies are to be mailed. The Privacy Official can tell you what the approximate cost will be to copy the information. If you request the information in some form other than photocopies, we will accede to your request if at all possible, and will charge a reasonable cost-based fee for providing the information in the alternative format. The Privacy Official can tell you what the approximate cost will be to reproduce the protected health information in the format you request.

You may also request in writing that we prepare a summary or explanation of your protected health information. We will do so for a fee. We can provide you with a request form, or you may mail a request letter to the Privacy Official. The Privacy Official can tell you what the cost will be to prepare the requested summary or explanation.

Request to Change Protected Health Information. In the event you believe that your protected health information is incomplete or inaccurate, you may request in writing that your protected health information be amended or corrected. The request must be in writing and must explain why you believe the information should be changed. We may deny your request under certain circumstances. We can provide you with a request form, or you may mail a request letter to the Privacy Official.

Request an Accounting of Disclosure and Use of Protected Health Information. Subject to certain exceptions, you have the right to know to whom we have disclosed your protected health information. The exceptions include (1) prior disclosures to you, (2) disclosures you authorized, (3) disclosures to carry out treatment, payment, and healthcare operations. In addition, the disclosures need not include those that took place before April 14, 2003, and in any event, disclosures that took place more than

six years prior to your request. If you request an accounting more than once during any twelve-month period, we will charge you a reasonable, cost-based fee for preparing the second response. We can provide you with a request form, or you may mail a request letter to the Privacy Official. The Privacy Official can tell you what the cost will be to prepare the accounting.

Request for Restriction on How Protected Health Information is disclosed to others. You have the right to request that we place additional restrictions on our use and disclosure of your protected health information. We are not required to agree to your request, but if we choose to do so, we will abide by the request, except in certain emergency situations.

Request for Alternative Communication of Protected Health Information. You have the right to request in writing that we communicate with you regarding your protected health information by alternative means or to an alternative location.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with us by contacting the Privacy Official or with the Secretary of the U.S. Department of Health and Human Services. If you file a complaint, you will not be retaliated against in any way.

Vicki Wood, Program Director
Adult Day Services
4601 N. Choctaw Rd.
Choctaw, OK 73020

(405)-390-4400

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.
Washington, D.C. 20201

U.S. Dept. of Health & EOC
Human Services
1301 Young St., Suite 1169
Dallas, TX 75202
(214) 767-4056
(214) 767-8940 (TDD)
(214) 767-0432 (Fax)

(HIPAA - Health Insurance Portability and Accountability Act)

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ADULT DAY SERVICES
4601 N CHOCTAW RD, CHOCTAW, OK 73020 • 405.390.4400

PHYSICAL EXAMINATION

Participant Name: _____ Date: _____

DOB: _____ SSN: _____

Ht: ____ft. ____ in. Wt. _____lbs. BP _____ P_____ Resp._____

Allergies: Medication: _____ Food: _____

MEDICAL DIAGNOSIS:

1. _____ 2. _____ 3. _____

4. _____ 5._____ 6. _____

TEETH: Own Teeth _____ Dentures: Y / N Upper __ Lower __

VISION: good ___ fair___ poor ___ Glasses: Y / N

HEARING: good ____ fair ____ poor ____ Hearing Aide: Y / N Right ___ Left ___

LUNGS: _____ **HEART**: _____

GI: _____ Constipation _____ Diarrhea _____ Incontinence _____

URINARY: _____ Chronic UTI _____ Incontinence _____

EXTREMITIES: _____Edema _____Skin Condition: _____

MENTAL STATUS:

Memory Loss: Y / N Short term: _____ Long term: _____

Dementia: Y / N Type _____ Stage _____

Depression: Y / N Anxiety _____ Other _____

Physician's Signature: _____ Date: _____

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Participant's Name:_____

CURRENT MEDICATIONS **Dosage** **Frequency**

_____

_____

_____

_____

Standing Orders:
_____ Tums, Antacid, Calcium Carbonate, 750 mg, 2 tabs PRN, for indigestion
_____ Tylenol 325 / 500 mg 1 or 2 tabs q 4-6 hrs PRN pain or elevated temp
_____ Imodium AD 1 caplet after each loose stool x2 PRN diarrhea
_____ OTC throat lozenges 1 for sore throat or cough PRN every hour x 3

Date of last Influenza injection: _____

DIET: General/Regular: _____ Mechanical soft:_____ Pureed:_____

General/Regular with Limited Concentrated Sweets: _____

General/Regular with No Added Salt: _____

Chewing difficulties: Y / N Swallowing difficulties: Y / N

ACTIVITY LEVEL: Full _____ Limited _____ Explain _____ _____

Assistive Devices: _____Cane _____Walker _____Wheelchair _____Braces

Fall Risk: Y / N

Physician's Signature: _____ Date: _____

Print name: _____

Address: _____

Telephone _____ Fax _____

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Re: _____ Date: _____

Dear Physician:

Enclosed please find a copy of Physicians Orders from Eastern Oklahoma County Technology (EOC) Adult Day Center. Although we are not a nursing facility providing 24-hour care, we do provide medical supervision of our participant's needs while they are with us during the day. All participants must have their Physician's Orders to attend our center so we may formulate a complete care plan for each individual.

State Health Department Regulations for adult day services require that a physician must sign/co-sign all orders with a ARNP or a PA-C. It is acceptable for a ARNP or PA-C to complete the examination, but a physician must co-sign.

Please complete the attached orders specifically for your patient's needs, sign them and give to patient to bring to us. Or if needed, you may fax them back to us at (405) 390-6637 when completed.

Sincerely,

Megan Hall, L.P.N.
Program Nurse
EOC Adult Day Center

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ADULT DAY SERVICES
4601 N CHOCTAW RD, CHOCTAW, OK 73020 • 405.390.4400

PHYSICIAN MEDICATION ORDERS

THIS FORM IS FOR MEDICATIONS TO BE GIVEN AT THE ADULT DAY CENTER ONLY

Name:_____ DOB:_____

SSN:_____

Medication Name	Dose	Route	Frequency/Time

*** Our facility is compliance with State Regulation, Title 310:605-13-2 from the Oklahoma State Department of Health.**

Physicians Printed Name: _____

Physicians Signature: _____ Date: _____

EOC Adult Day Center:
Program Nurse Signature: _____
Date:_____