



# The Riggs-Scott Care Center

Adult Day Services on the campus of The Baptist Home

P.O. Box 87  
101 Riggs Scott Lane  
Ironton, MO 63650  
573-546-7429  
573-546-6212 (fax)  
www.thebaptisthome.org

## Application

Date \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Last First

Address \_\_\_\_\_  
Street City State Zip

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Previous Occupation \_\_\_\_\_ Years Retired \_\_\_\_\_

Source of Referral \_\_\_\_\_

Religion \_\_\_\_\_ Home Church \_\_\_\_\_

Person (s) to contact in case of an emergency:

|    | Name  | Relationship | Address | Phone |
|----|-------|--------------|---------|-------|
| 1. | _____ | _____        | _____   | _____ |
| 2. | _____ | _____        | _____   | _____ |
| 3. | _____ | _____        | _____   | _____ |

Attending and Alternate Physician:

|    | Name  | Address | Phone |
|----|-------|---------|-------|
| 1. | _____ | _____   | _____ |
| 2. | _____ | _____   | _____ |

Choice of Hospital \_\_\_\_\_

Medical Diagnosis \_\_\_\_\_

Diet Restrictions \_\_\_\_\_

Mental Functioning: \_\_\_\_\_Alert \_\_\_\_\_Confused \_\_\_\_\_Forgetful

Briefly describe the applicant's mental status \_\_\_\_\_  
\_\_\_\_\_

Physical Functioning

Walking Ability:

\_\_\_\_ Unassisted  
\_\_\_\_ Needs Assistance  
\_\_\_\_ Uses Appliance Cane \_\_\_\_ Walker \_\_\_\_ Crutches \_\_\_\_ Wheelchair \_\_\_\_

Vision:

\_\_\_\_ Good \_\_\_\_ Wears Glasses \_\_\_\_ Contacts \_\_\_\_ Limited \_\_\_\_ Blind

Hearing:

\_\_\_\_ Good \_\_\_\_ Wears Aid \_\_\_\_ Hard of Hearing \_\_\_\_ Deaf

Feeding:

\_\_\_\_ Unassisted  
\_\_\_\_ Needs Assistance

Toileting:

\_\_\_\_ Self-Care \_\_\_\_ Able to Control Bladder \_\_\_\_ Able to Control Bowels  
\_\_\_\_ Wears Depends/Briefs \_\_\_\_ Needs Monitoring

Bathing:

Applicant needs frequent (more than once a day) bathing: Yes or No

Note: As a courtesy, two baths per month can be provided free of charge. If during the course of the applicant's stay at the Riggs-Scott Care Center more frequent bathing is required, the family will be notified and the applicant will be charged \$10 per additional bath.

Other (describe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social and Emotional Functioning:

Describe how the applicant relates to other people \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Activities preferred (Include special interests and skills): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other concerns (describe) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**24 hour notice will be required to ensure adequate staffing and meal preparation.**

Hours of Operation: Monday thru Friday – 6:00 a.m. to 6:00 p.m.

|                | <u>Indicate Hours of</u> |                | <u>(X) Meals Preferred:</u> |              |               |
|----------------|--------------------------|----------------|-----------------------------|--------------|---------------|
|                | <u>Drop-off</u>          | <u>Pick-up</u> | <u>Breakfast</u>            | <u>Lunch</u> | <u>Dinner</u> |
| ____ Monday    | _____                    | _____          | _____                       | _____        | _____         |
| ____ Tuesday   | _____                    | _____          | _____                       | _____        | _____         |
| ____ Wednesday | _____                    | _____          | _____                       | _____        | _____         |
| ____ Thursday  | _____                    | _____          | _____                       | _____        | _____         |
| ____ Friday    | _____                    | _____          | _____                       | _____        | _____         |

**Rates:**

- \$40 – Half Day (4 ½ hours, w/one meal)
- \$60 – Full Day (9 hours, w/one meal)
- \$5.00 per hour beyond a 9 hour stay (not to exceed 12 hrs.)
- \$3.00 per additional meal

**Please list those individuals authorized to pick up the applicant from the program:**

Photo ID must be presented at time of pick up.

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Relationship \_\_\_\_\_

\_\_\_\_\_  
 Signature of Personal Representative Date

\_\_\_\_\_  
 Relationship

\_\_\_\_\_  
 Facility Representative Date