Welcome To Add To Life Adult Daycare

Helping families stay together!

Thank you for your time, we appreciate you checking out our daycare and choosing to pursue the application process. This packet has step-by-step instruction sheets to help make the application process as easy as possible. For additional help please contact:

Add To Life Adult Daycare Inc.
5877 Old Timuquana Road
Jacksonville, Florida 32210
Phone(904)779-1777
Fax(904)779-1711
Email: daycare adult@yahoo.com
Website: www.AddToLifeAdultDaycare.com

- Instructions:
- The first
  is your funding application.
- Fill out your funding application to the best of your knowledge and return with the rest of your packet to Add To Life.
- Add To Life will fax your funding application to help you get funding as fast as possible.

CARES INTAKE FORM

DEMOGRAPHIC

SSN: _____/_____/_____

First Name: _____ MI: ____ Last Name: _____

Date of Birth: ____/____/_____ Date of Death: ____/____/_____ Medicaid Number: _____

Medicare A & B: _____ Medicare HMO _____ Medicare Number: _____

Race: _____ *A=Asian/Pacific Islander B=Black NA=Native American O=Other U=Unknown W=White*

Ethnicity: _____ *H=Hispanic O=Other U=Unknown*

Sex: ____ *F=Female M=Male* Marital Status: _____ *D=Divorced M=Married P=Separated S=Single U=Unknown W=Widowed*

Address 1: _____ Address 2: _____

Zip Code: _____ City: _____ State: _____

County of Residence: _____ County of Service: _____ Phone Number: (____) _____

CASE ASSIGNMENT

Initial Date: ____/____/_____ Assigned To: _____ Referral Source: _____

Referral Source Name: _____ Phone Number: (____) _____

A=Abuse/Neglect	*C=CARES*	*H=Hospital*	*PAC=Project Aids Care Assn*
AFCH=Adult Family Care Home	*CDCW=Consumer Dir Case Wrkr*	*L=Land Agency*	*PSYF=Psychiatric Facility*
AP=Adult Payments	*CHA=Channeling*	*LTCP=LTC Comm Div Pil Prog*	*SELF=Self*
AAS=Adult Services	*DES=Developmental Services*	*MHC=Miranda Home Care*	*SNUH=Skilled Nurs Unit/Hospital*
AHCA=Agency for Health Care Adm	*ELD=Elder Care*	*NH=Nursing Home*	*SMHO=State Mental Hospital*
ADM=Alcohol/Drug/Mental Health	*FAM=Family*	*O=Other*	*SBHO=Suing Brd Hospital*
AAA=Area Agency on Aging	*FRIN=Friend, Neighbor*	*OMW=Other Med Wrkr*	*UHC=United Home Care*
ALF=Assisted Living Facility	*HMO=Helath Maint Org*	*PHY=Physician*	*UPP=Upcoming Project*
BHP=Broward Homebound Prog	*HHC=Home Health Care*	*PRIS=Prison/Jail*	*VOC=Vocational Rehabilitation*

Payment Type: _____ *MEDI=Medicaid MEDP=Medicaid Pending PRPA=Private Pay*

Living Arrangement: _____

APCH=Adult Family Care Home	*ALFN=ALF with Limited Nurs*	*OTHR=Other*	*SMHO=State Mental Hospital*
ARTS=Adult/Geriatric Res Treat Fac	*GRHO=Group Home*	*PRIS=Prison/Jail*	*SMNH=State Mental Hospital/NH*
ALFS=Assisted Living Facility	*HOSP=Hospital*	*PRRE=Private Res*	*SAPT=Supervised Apartment*
ALFE=ALF with Ext Cong Care	*MRDD=MR/DD Facility*	*PSYF=Psychiatric Fac*	*TRAN=Transient*
ALFM=ALF with Limited Ment Heal	*NUHO=Nursing Home*	*REHB=Rehab Hosp*	

Living Situation: _____ *AL=Alone WC=With Caregiver WO=With Other U=Unknown*

Special Project Case: _____ *N=None L=Long Term Care Comm Diversion Pilot Program U=Upcoming Project*

Provider Name: _____ Primary Caregiver: _____ *N=No Caregiver U=Unknown Y=Yes*

Open Reason: _____ *AR=Annual Waiver Recert IN=Initial Case OT=Other RE=Reassessment TR=Transferred*

ADDITIONAL CLIENT INFORMATION

Client Home Address: _____

_____ Zip Code: _____

Phone Number: (____) _____

Directions: _____

_____

Responsible Party: _____ Relationship: _____

Phone Number: (____) _____

Caregiver Name: _____ Phone Number: (____) _____

Primary Physician: _____ Phone Number: (____) _____

Intake Signature: _____ Date _____

Very Important section

The next five pages of the application are medical release forms.
The purpose of the forms is to show that your loved one is free of communicable diseases, including TB. While also giving us an overview of their medical conditions and other important health information to help us better care for your loved one.

Your doctor can choose to fill out Form A (state medical release 3008 form) or Form B (Add To Life's medical release form).
Both forms are acceptable!

Chest x-ray will be acceptable up to 1 yr and TB test is acceptable for 45 days. The test will have to be in this time frame to enter daycare or the test will have to be done again.

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

FORM A

A PATIENT TRANSFER AND CONTINUITY OF CARE

Facility To: _____ Facility From: _____ Hospital Admission/ Discharge Dates _____

B

PATIENT'S DOB ___/___/___ SEX ____ RACE _____

PATIENT'S LAST NAME FIRST NAME INITIAL

PATIENT'S ADDRESS APT. PHONE

NEAREST RELATIVE PHONE

PHYSICIAN INFORMATION

NAME _____ PHONE _____

Will you care for Patient in NH? Yes No If not, referred to : _____

Principle Diagnosis: _____

Secondary Diagnosis: _____

Discharge Diagnosis: _____

Surgery Performed & Date _____

MEDICATION AND TREATMENT ORDERS (copies may be attached)

C

1. Is dementia the primary diagnosis? ☐ Yes ☐ No
2. Is there a diagnosis or presenting evidence of mental retardation, or has the client received MR services within the past 2 years? ☐ Yes ☐ No
3. Has the client received MI services within the past two years? ☐ Yes ☐ No
   Is there any presenting evidence of mental illness such as: (Check all that apply)
   - ____ Schizophrenia
   - ____ Mood
   - ____ Somatoform disorder
   - ____ Paranoia
   - ____ Panic or severe anxiety disorder
   - ____ Personality disorder
   - ____ Other psychotic or mental disorder leading to chronic disability
4. Is the client a danger to self or others? ☐ Yes - Please attach explanation ☐ No
5. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis? ☐ Yes ☐ No
6. If yes, is the mental illness or psychiatric diagnosis controlled with medication? ☐ Yes ☐ No

D

☐ OXYGEN
LMIN _____
NASAL CANNULA
MASK
PRN
CONTINUOUS

☐ SUCTIONING
FREQUENCY _____

☐ TRACH CARE
FREQUENCY _____
SIZE _____

☐ OSTOMY CARE
FREQUENCY _____

☐ TUBE FEEDINGS
FREQUENCY _____
TYPE OF FEEDING _____

☐ CHANGE FEEDING TUBE
FREQUENCY _____

☐ CATHETER
DATE LAST CHANGED _____
SIZE _____ TYPE _____

☐ IRRIGATE CATHETER
FREQUENCY _____
SOLUTION _____

☐ DRAINING WOUND
CULTURED _____
DATE _____
RESULTS _____

☐ DRESSING
TYPE _____
FREQUENCY _____

☐ DECUBITUS CARE
SITE _____
SIZE _____
STAGE _____
MEDICATION/SOLUTION _____

E

SOCIAL SEC. NO. _____

HEALTH INS. CLAIM _____

MEDICARE CLAIM NO. _____

MEDICAID CLAIM NO. _____

LANGUAGE _____

F

ADVANCED MEDICAL DIRECTIVE:
☐ YES ☐ NO ☐ COPY ATTACHED

NAME OF SURROGATE _____

G

PHYSICAL EXAM (may attach)

Heent: _____

Neck: _____

Cardiopulmonary: _____

Abdomen: _____

Gu: _____

Rectal: _____

Extremities: _____

Neurological: _____

Allergy/Drug Sensitivity: _____

Free from communicable diseases? ☐ Yes ☐ No

H

BRIEF MEDICAL AND MENTAL HISTORY
(may attach progress notes) _____

MAJOR TESTS AND RESULTS _____

LABORATORY FINDINGS (may attach reports)

CHEST X-RAY DATE _____
RESULTS _____
C B C DATE _____
RESULTS _____
URINALYSIS DATE _____
ALBUMIN _____
SUGAR _____
ACETONE _____
TB TEST ☐ YES ☐ NO RESULTS _____

I

TYPE OF CARE RECOMMENDED:

☐ **Skilled Nursing (ECF) Duration** _____
☐ **Intermediate Care Duration** _____
Circle Rehab Potential Good Fair Poor
Admission Date to Nursing Home ___/___/___

☐ I certify that this patient requires E.C.F. Nursing Home Care for the condition for which he/she received care during hospitalization.
Effective Date ___/___/___

Physician's Signature (valid for both pages) Date

PRINT PHYSICIAN'S NAME _____

ADDRESS _____

PHONE NUMBER _____

Federal law mandates the physician's signature; all other signatures on the form are optional.

Form B

MEDICAL RELEASE FORM

Date _____

_____ has been found free from TB in a communicable state as demonstrated by _____ (PPD or x-ray) and is apparently free of signs and symptoms of other communicable diseases.

_____

Physician's Signature

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5877 Old Timuquena Road
Jacksonville Fl, 32219
(904) 779-1777

Applicant Initial_____

Initial _____
Annual _____

PHYSICIAN'S ORDERS

Client _____

Address _____

_____

Insurance: _____

Social Security Number: _____

Medicare #: _____

Date of Birth: _____

Current Diagnosis: (Physical or Mental)

_____
_____
_____
_____
_____

Current Medications (Over the Counter medications Included)	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Tylenol 500 mg	1-2 Tablets	PRN

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Applicant Initial_____ _____

____ I certify that patient may self-administer medications.
____ I certify that medication may be given as listed above.

Mobility: Ambulatory ____ Cane _____ Walker _____
Wheelchair _____

Physical Limitations:

_____
_____
_____
_____

Diet: _____ Regular _____ Low Salt _____ Low Salt/Low Sugar
_____ Ground _____ Pureed _____ Low Fat _____ Diabetic

Allergies: (Medications and/or Food)

_____
_____
_____

Vital Signs: Blood Pressure _____ Pulse: _____
Respiration: _____

Communicable Disease: All tests must be done within 45 days prior to admission to Add To Life Adult Day Care Center

Is this client free of communicable disease? _____ Yes _____ No

TB Test: Date of TB test _____
Results: _____

OR

Chest x-ray: Date of x-ray _____
Results: _____

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Applicant Initial_____

Form B

Special Health and Safety Needs:

_____
_____
_____

COMMENTS:

_____
_____
_____
_____
_____

Date of last office visit: _____

This client may be at risk for institutionalization if not admitted to an adult daycare program.

Medication changes require a new order that will be sent to you.

_____ _____
Physician's Signature Date

_____
Physician's Name (PLEASE PRINT)

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Applicant Initial_____

Last section

The last half of the paeket is to tell us about your loved one; likes, dislikes, and basic information about them. While also informing you of the services we provide and it goes over rights and choices of your loved one.

Finished?

If you have filled out the packet to the best of your knowledge and have your TB test (Form A or Form B) , then you can come on into the daycare and we will take care of the rest.

If you have any questions please don't hesitate to call!!!

HOW DID YOU HEAR ABOUT US? _____

Date of enrollment:_____ **Daily Fee:**_____

CLIENT INFORMATION

Personal Information

_____

Name (last) (first) (MI) Date of birth Age Sex

_____

Religion

_____

Address City State Zip Code Telephone#

_____

Marital Status Social Security # Medicare # Medicaid #

Emergency Information

Emergency contact or guardian/responsible party

Name: _____
Relationship: _____
Address:_____
Telephone (home): _____
(work): _____

Nearest Relative

Name: _____
Relationship: _____
Address:

_____

Telephone (home): _____
(work): _____

Non-local Relative

Name: _____
Relationship: _____
Address:

_____

Telephone (home): _____
(work): _____

Attending Physician(s)

Name: _____
Telephone: _____
Address:

_____

Hospital Emergency: _____
Ambulance Service: _____

CLIENT'S PERSONAL INFORMATION

Former Occupation: _____

Educational Background: _____

Presently living with: _____

Spouse's Name: _____

Children's Name: _____
(if any)

Other family (names, relation, location):

_____

_____

_____

Most Frequent Contact: _____

Does client receive services from any local agencies? (Visiting nurses, Meals-on-Wheels, counseling, therapy, church, etc.):

_____
_____

DOES CLIENT INDICATE NEED TO GO TO THE BATHROOM?_____
IF YES, HOW? _____

IS CLIENT INDEPENDENT IN ANY HOUSEHOLD ACTIVITIES? (LAUNDRY, HOUSEWORK, MEAL PREPARATION, SHOPPING, USING PHONE)
DESCRIBE:

_____
_____

Does client have bladder control? _____ Bowel control? _____

If no, check one: _____ Occasional incontinence
_____ Frequent incontinence

Interests/Activities

Does client:	No	Yes	Details if significant
Enjoy music? (types)			
Watch TV? (favorite program)			
Play musical instrument?			
Like gardening?			
Enjoy pets?			
Enjoy painting?			
Enjoy cooking?			
Enjoy woodcrafts?			
Enjoy sports?			
Enjoy exercise?			
Enjoy arts and crafts?			
Enjoy magazines or books?			
Enjoy sewing?			

Does client smoke? _____
Frequency: _____

Does client drink alcoholic beverages? _____
Frequency: _____

Special Hobbies:

_____

Does client demonstrate: No Yes Details if significant

Significant memory loss?
Frequent mood changes?
Frequent wandering?
Paranoia?
Hostility?
Denial?
Confusion?
Depression?

Describe current sleep patterns:

_____

Describe current eating habits:

_____

Type of diet: _____ Regular _____ Low Sodium _____ Diabetic
_____ Other

Can client feed himself? _____
Need assistance or direction? _____

Does client have natural teeth? _____ Dentures: (uses) _____
(not used) _____

Food preferences:

_____

Beverage preferences:

_____

Specific food/drink dislikes:

_____

Does client have any assistive devices?
_____ Eyeglasses _____ Hearing Aid _____ Colostomy
_____ Brace
_____ Other Prosthesis _____ Wheelchair, cane, walker

PHYSICAL HISTORY:

DATE OF MOST RECENT MEDICAL EXAM: _____

HAS CLIENT BEEN HOSPITALIZED IN THE LAST YEAR?_____

IF YES, DATES/REASON FOR HOSPITALIZATION:

_____

CURRENT PRESCRIPTION MEDICATIONS AND DOSAGE:

_____

_____

_____

_____

OTC MEDICATIONS TAKEN REGULARLY:

_____

_____

OTHER MEDICAL HISTORY:

_____

_____

_____

PHYSICIAN APPOINTMENT SCHEDULE:

_____

LONG-TERM GOALS:

_____

SHORT-TERM GOALS:

_____

Behavioral/Functional

Onset of Symptoms:

_____

When was client diagnosed?

_____

Subject: Release Form

The undersigned client, responsible relative, guardian (underline one) of _____ hereby authorize consents to said client's use of the facilities and equipment provided by Add To Life Adult Daycare Center, Inc. I/We also release Add To Life's officials, agents, employees, and/or other person, firm, or corporations charged or chargeable with responsibility or liability from any and all claims, demands, damages, costs, expenses, loss of services, actions, and cause of action, which could arise out of any act or occurrences and particularly on account of personal injury, sustained by the said client, while said client is on the premises of a facility operated by Add To Life Adult Daycare Center, Inc.

Authorization is also granted:

1. To any physician, hospital, clinic, or medical service for the release of medical and/or psychiatric information on said client to Add To Life Adult Daycare Center, Inc.
2. To any social service agency for the release of information to Add To Life Adult Daycare Center, Inc. regarding its contact with said client.
3. For the release of any necessary information on the said client by Add To Life Adult Daycare Center, Inc., to its agencies and or medical equipment personnel in order to obtain appropriate requisite services.
4. For the use in publicity releases of photographs of activities involving said client.
5. To Add To Life Adult Daycare Center, Inc. to secure any emergency medical service as needed in the event that I can not be contacted immediately.
   Preferred hospital is _____ and
   Primary Care Physician is _____.

_____ _____

Client's Name Client's Signature

_____ _____

Relative Guardian's Name Relative Guardian's Signature

_____ _____

Director's Signature Date

Add To Life Adult Day Care
5877 Old Timuquana Road
Jacksonville Fl, 32219
(904) 779-1777

Applicant Initial_____

RATE AGREEMENT

Daily charges will be based on Medicaid rates per day. As of 04/01/2009 a rate increase became effective for all CCE/ADI/MW/3E funded clients. The new rate is $8.56 per hour, or a flat $63.00 day rate. Clients funded by outside sources, subject to contract agreement. Scholarships may be available for non-funded clients.
Payment is required at the beginning of the week and/or month. Funded clients must have current service authorizations on file.

If you know that the client will not be attending on a regularly scheduled day, to avoid being charged for that day, twenty-four (24) hours notice must be given.

Refund policy: Since payment is made at the beginning of the week/month, any excess payment will be credited toward the following week.

DATE: _____

DAILY RATE: _____

I have received a copy of Add To Life Adult Daycare Center's policies. I hereby agree to comply with the stated policies and procedures and to respect the personal rights and private property of the other participants.

_____

Participant's/Guardian's Signature

_____

Director's Signature

Add To Life Adult Day Care
5877 Old Timuquana Road
Jacksonville Fl, 32219

Applicant Initial_____

Admission Criteria

PARTICIPANTS SHALL BE:

--Individuals with a diagnosis of Alzheimer's Disease or a related disorder determined by medical assessment including: CT Scan, neurological exam, and blood tests.

Or

--Individuals over age 18 with learning challenges experiencing decreased awareness, confusion, disorientation, withdrawal, paranoia, memory impairment, loss of social skills, and/or increased dependency who are in need of a protective environment free of health and safety hazards.

--Free of communicable diseases-evidenced by attending physician's statement (with negative TB test or acceptable chest x-ray completed within 45 days of acceptance to program)

--Admitted subject to a 30 day probation period in which the participant is found to adjust and benefit from the environment.

--Those having completed all necessary admission forms:

1. Medical Statement
2. Agreement Contract
3. Client Information Data
4. Medication Administration/supervision permission (where applicable)

If client has monies/valuables--WE ARE NOT RESPONSIBLE FOR THE LOSS, IF ANY, OF THESE--PLEASE DO NOT BRING VALUABLES WITH YOU!

The Add To Life Adult Daycare Center's eligibility guidelines and Program Policies have been discussed with me (client) and/or significant members or friends. I understand this information and agree to abide by these policies.

_____ _____

Client Signature Date

_____ _____

Guardian/Family Member/Caregiver Date

_____ _____

Daycare Director Date

Add To Life Adult Day Care
5877 Old Timuquana Road
Jacksonville Fl, 32219
(904) 779-1777

Applicant Initial_____

ADMISSION AGREEMENT

The Add To Life Adult Daycare Center, Inc. agrees to offer needed Adult Day Health Care services, including, but not limited to, nutritional services, recreational activities, social service, and nursing services by a registered nurse, and/or LPN when RN is not available.

In return, the client agrees to attend ( ) days a week for a minimum of four hours.

The Add To Life Adult Daycare Center, Inc. is closed on the following holidays. (See holiday insert for any differences)

1. New Year's Day
2. Memorial Day
3. Independence Day
4. Labor Day
5. Thanksgiving
6. Christmas

In case of inclement weather, we will announce our closing on Channel 12 and 25 (First Coast News).

_____ _____

Director Client/Legal Guardian

Add To Life Adult Day Care
5877 Old Timuquana Road
Jacksonville FL, 32219
(904) 779-1777

Applicant Initial_____

Updated 4/1/09

Attention: All Family Members of Add To Life Adult Daycare Center's client

Re: Emergency Procedure

This memo is to inform you of the procedure that will be followed in case of an emergency (hurricane, fire, terrorism, etc.)

1. Channels 12 and 25 (First Coast News) will be notified of any closures and the length of any closures.
2. All clients, if at the daycare, will be escorted home as soon as possible.
3. As a last resort, any clients who are unable to be transported home will be transported to The Terrace at Fleming Island, Orange Park, Florida. We have a mutual aid agreement to provide this service for their facility as well.

This is simply to inform you of the procedure and to allow you to have this information on hand in case of an actual emergency. Please make a copy for your own records and return this one.

Thank You,

Cindy B. Dixon, Director Add To Life Adult Daycare Center

_____ _____

Client/Guardian's Signature Date

_____ _____

Director's Signature Date

Add To Life Adult Day Care
5877 Old Timuquana Road
Jacksonville Fl, 32219
(904) 779-1777

Applicant Initial_____

The next page is for ADT clients only, if you are applying for a senior citizen- please disregard the following page only.

Adult Day Training Contract

Adult Day Training funding covers six (6) hours of funded time at ADD TO LIFE ADULT DAY CARE CENTER. After this allotted time has expired each day the consumer that remains at the center after 6 hours is no longer within the Adult Day Training program. He/she is then enrolled in the Adult Day Care program. On the days that this occurs the family/caregiver is then financially responsible for any overtime accrued after their allotted six (6) hours.

_____ _____

Caregiver signature Date

_____ _____

Director signature Date

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5877 Old Timuquana Road
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(904) 779-1777

Applicant Initial_____

To All Families of Add To Life Adult Daycare Center's Clients

If transportation is provided by JTA for your family member, it is of utmost importance that you or someone at your home assists the driver in loading the client from the van. JTA drivers maintain a very tight schedule and are on a very tight time limit when providing this service to you and your loved one. Any assistance you provide will allow them to be more accurate on their arrival times.

Transportation must be provided personally or by JTA, if so chosen.

If JTA is the means of transportation for your loved one please follow the following:

1. Be ready 20-30 minutes before estimated pick-up time.
2. Have client dressed, groomed, and toileted before pick-up.
3. Driver is only able to wait 5 minutes for passenger to leave the house.
4. Be prepared for a delay due to traffic or weather.
5. If they have not arrived by the estimated pick-up or drop-off time, please call and we can check on estimated arrival time or you may call JTA at 265-6999.

Your cooperation in this matter would be greatly appreciated.

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5877 Old Timuquana Road
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(904) 779-1777

Applicant Initial_____

Adult Day Health Care (ADHC) is an alternative to nursing home placement. The program is open to elderly individuals, including those with physical and memory (Alzheimer's) problems, as well as to individuals 18 years of age or older who may have special needs. ADHC provides a therapeutic, protective, structured, and supportive environment five days a week on a regularly scheduled basis. One of the local organizations that provide ADHC is Add To Life Adult Daycare Center.

Add To Life is open for ten hours per day (7:30-5:30), five days a week. Social interaction, professional and peer support, exercise, mental stimulation, health monitoring, assistance with eating, walking, toileting, and medication are some of the many services that are offered to the participants every day at Add To Life. There are also structured activities such as music, art, and reminiscence therapy. Caregivers also benefit from the program. While their loved one is attending the program, caregivers can use the time to meet family obligations or to enjoy some much needed rest and relaxation.

The Lunch provided meets 1/3 of the minimum recommended dietary allowance requirements. Lunch is provided, along with breakfast and an afternoon snack. Transportation is available to and from the Adult Health Care Facility; see director for contract information.

Add To Life Adult Day Care
5877 Old Timuquana Road
Jacksonville Fl, 32219
(904) 779-1777

Applicant Initial_____

Adult Daycare Eligibility

1. Add To Life Adult Daycare is a program provided for Adults with Special Needs. The purpose of Adult Daycare is to provide protective individual supervision in a safe, and pleasant environment. Activities are provided, which include arts and crafts, puzzles, games, discussion groups, exercise, hygiene classes, individual training programs, reality orientation, movies, outings, etc. These activities help the clients remain as active and independent as possible for a longer period of time. Consultant Referral Services are provided upon request or as indicated.

2. If a client is determined to be appropriate, physician orders and a current TB test or chest x-ray must be completed to comply with department rules. Physician orders and physical exams must be renewed as medications change or there is a change in client health.

3. Participants are responsible to comply with these policies and procedures and to respect the personal rights ad private property of other participants.

Add To Life Adult Day Care
5877 Old Timuquana Road
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(904) 779-1777

Applicant Initial_____

Program Policies

1. Hours of operation

The program is open from 7:30 am to 5:30 pm, Monday through Friday. Closing will occur promptly at 5:30 pm. A late fee will be assessed for clients not picked up by 5:30 pm. Respite care will be charged @ $12.00 per hour after 5:30p.m., a charge of $10.00 every 15 minutes. Transportation of clients through JTA service will be coordinated by staff and JTA.

2. Incontinence

Protective undergarments are acceptable for loss of bladder control. Please send in at least two extra per day.

3. Special Assistance

The staff is always available to provide assistance to clients. Persons regularly requiring the simultaneous assistance of more than one staff person are considered on an individual basis.

4. Hygienic Standards

It is very important that all clients have good hygiene. Good hygiene means a clean body (including mouth and hair) and clothes. In case of poor hygiene, staff will advise the client and/or caregiver and assist with helping to solve the problem through referrals and/or education and/or individual attention.

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Applicant Initial_____

5. Medicines

Administer medication to the client in accordance with the following criteria:

-Medication prescribed for administration during the day care hours of service must be properly labeled with name of medication, pharmacy number, prescribing physician, dosage, and times of administration. Medication should also come in a bottle directly from the pharmacy.

-Medication to be administered will remain on premises for duration of client's participation in the program.

-Medication renewals will be the responsibility of client or responsible party.

-If the client refuses medication, the responsible party will be notified.

6. Bed Rest

A day bed is available for clients who become ill and need to lie down. Otherwise, comfortable easy chairs, couches, and recliners, are available for reclining.

7. Activities

A variety of activities are scheduled and all clients are encouraged to participate.

8. Wandering

To ensure clients' reasonable safety, determination of the appropriateness of clients who are prone to wandering will be made on an individual basis. Alarms and fences are in place.

9. Combative Behavior

The participation of persons who are routinely hostile, combative, or verbally abusive to others (clients or staff) will be terminated. The client will be allowed to remain as a client if behavior problems can be controlled by mediations or behavior management.

10. Termination from the Program

These policies and standards were developed to ensure a healthy, pleasant, stimulating environment for all clients and staff. A client who does not meet these standards will be re-evaluated to determine cause for termination from the program. In such situations, an individual conference with the client, caregiver, and/or case manager may be scheduled to assess the situation. In all cases, the client and/or caregiver will be given a minimum of one week of prior notice to the termination date. When safety is an issue due to progression of symptoms, these clients will be dealt with on a one to one basis.

11. Volunteers

Adult daycare utilizes volunteers from the community, local schools, and universities. There are many volunteer opportunities.

12. The client or Responsible Party agrees to:

-Complete or provide all necessary client-related forms prior to admission.
-Notify the daycare at least seven (7) days prior to client's intended date of discontinuance in the program
-Provide changes of labeled clothing and undergarments to be stored at the center.
If client uses incontinence diaper, an adequate supply should be provided for each day.

-Absolve the daycare of liability for any loss or damage to the client's personal property or valuables to fire, theft, or other mishaps.
-Absolve Add To Life Adult Daycare Center, Inc.'s officials, employees, and/or any other person, firm, or corporation charged or chargeable with responsibility or liability from any and all claims, damages, costs, expenses, loss of services, actions, and cause of action, which could arise out of any occurrence, and particularly on account of personal injury, sustained by the said participant, while the participant is on the vehicles arranged/owned by the daycare.
-Authorize the daycare to transport the client off the premises for planned outings, neighborhood walks, or community events, etc. as part of the therapeutic programming.
-Accept the decision of the daycare regarding discharge of the client due to concerns for his/her safety or that of others.

13. Authorize the daycare to:

-Use pictures or identifying information regarding the client for publicity purposes or use in an emergency.
-Release information regarding the client for publicity purposes or use in an emergency.
-Transport clients to the nearest emergency facility in the event of an acute illness if family or responsible persons cannot be reached.

14. a. Pay the daycare the daily rate _____ at the beginning of the week or month, plus transportation.
b. Allow the daycare to submit third party billings monthly for services rendered, if necessary, if covered.
c. Add To Life Adult Day Care Center hours are from 7:30 am to 5:30 pm.
d. A late fee of $10.00 will be charged for each fifteen minutes past 5:30 pm, or agreed time for client to be picked up.
e. Client will attend daycare _____ per week on the following days _____.

I have read and understand the above items and agree to abide by them.

_____ _____

Legal Caregiver/Client Date

Add To Life Adult Day Care
5877 Old Timuquana Road
Jacksonville Fl, 32219
(904) 779-1777

Applicant Initial_____

Emergency Preparedness Information

As part of the center's Emergency Management Plan to keep your loved one safe we offer annual evacuation information. We have the forms you need to complete if you wish for special services in the case of a disaster. There are two forms for those with special needs. One form is to have **evacuation transportation to a shelter**, the other form is for the intent of **staying in a shelter in the event of a disaster.**

You may request one or both of these forms,

Please inform the center if you have any interest.

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FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

STATE OF FLORIDA DEPARTMENT OF ELDER AFFAIRS

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
DEPARTMENT OF ELDER AFFAIRS

INFORMED CONSENT FORM

CLIENT'S NAME: _____

SOCIAL SECURITY # : _____

An assessment is required for all persons applying for or receiving assistance for long term care. This includes the Institutional Care Program (ICP) and Home and Community Based Services (HCBS) waiver programs.

In order to evaluate my needs, I am giving my consent to the following:

- I agree to an assessment to identify my need for long term care, and to determine if my needs can be met in the community instead of a nursing facility.

- I authorize DC&F and DOEA staff to access my medical records . I understand and agree that DC&F and DOEA may need to talk to my doctor and other health professionals. I also understand that they may need to interview family members, close friends and social services professionals about my situation.

_____
Individual or Representative

_____
Relationship (if representative signs)

_____
Date

CF-ES 2040, Sep 2000 (Replaces Jan 98 edition which may be used)
(Stock Number: 3CF-00277)

Patient record of disclosures

In general, the HIPAA privacy rule give *individuals* the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone:
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. To mail to my work/office address
- ☐ O.K. To fax to this number

_____

☐ Work Telephone Number: _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

_____

Patient Signature	Print Name	Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual

Healthcare entities must keep records of Protected Health Information disclosure. Information provided below, if completed properly, will constitute an adequate record.

*** Note: Uses and disclosure of Protected Health Information may be permitted without prior Consent in an emergency.**

RECORD OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date	Disclosed To	(1)	Purpose of Disclosure	By Whom Disclosed	(2)	(3)

1 Check this box if the disclosure is authorized.

2 Type Key: **T** = Treatment Records; **P** = Payment Information, **O** = Healthcare Operations

3 Enter how disclosure was made: **F** = Fax; **P** = Phone; **O** = Other

"Bill of Rights"

This bill reaffirms all those inalienable rights guaranteed in the U.S. Bill of Rights while setting forth 12 specific rights for all citizens:

- The right to dignity, privacy and humane care
- The right to religious freedom and practice
- The unrestricted right to communication
- The right to personal possessions and effects
- The right to education and training
- The right to prompt and appropriate medical care and treatment
- The right to social interaction
- The right to physical exercise
- The right to human discipline
- The right to minimum wage protection and fair compensation
- The right to be free from physical restraint
- The right to a central record

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PRINCIPLES OF CHOICE

- All people have the right to make choices.
- People have the right to learn about choices through exposure to natural life experiences, making mistakes, naturally occurring consequences, training and through seeking advice from others.
- All people with disabilities have the right to receive impartial information concerning choices. Undue, imbalanced or self-serving influence is not acceptable
- Factors that limit choices for people with disabilities should not differ from those for people without disabilities.
- People have the right to choose from a variety of supports and services and make changes based on their individual needs.
- People should be offered options which are free from threats to their immediate health and safety or the immediate health and safety of others.
- Consistent with other principles of choice, people have the right to make an informed choice of any qualified provider of any needed service or support.
- The choices people make do not diminish the obligation to act in a responsible manner and to accept the consequences of their choices.

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Choice and Empowerment

(standard 1.B6-cite 15/16-C.A)

As a provider, I recognize the need for individuals to be encouraged to make their own decisions. I view individuals I serve and their families as partners in meeting the person's service needs.

I am committed to creating opportunities for individuals to make choices throughout the services I provide. The choice making ability of each individual served by me will be reviewed at the time of first meeting with the person, throughout the support plan year, and annually thereafter during the individual's support plan meeting. Training will be provided in those areas that are identified as a need.

The individual is encouraged to identify his/her choices and needs and to share them with me. Through meetings with the person, and other individuals they wish to invite, priority outcomes are determined. An implementation plan is developed within 30 days of beginning a new service and within 30 days of the effective date of service authorization for ongoing services. This plan directly relates with the stated outcome from the support plan for the service I provide. The implementation plan will include specific plans of how to assist the person in meeting their stated outcomes as well as those that ensure health and safety. The implementation plan may be changed throughout the support plan year as personal outcome are met, the person's preferences change, or if different approach should be used to ensure achievement of the outcome.

All individuals receiving services are expected to fully participate in the development of their individualized plan. The person determines the services and how they are provided as well as the outcomes to be addressed. If an individual has a hard time understanding and/or making choices or in understanding the consequences of making choices, I will help them in trying to find an involved caregiver/friend to help with this process.

To further encourage choice making, individuals receiving services participate in community training activities and are given chances to choose where they would like to go, what they would to purchase.

I fully inform individuals that they have a right to due process should they be unhappy with the services being provided and have the right to choose a new provider should we not be able to work out any problems between us. A person's ability to make choices as described in this policy will be reviewed with the person each year.

My rights related to choice making have been fully explained to me.

_____ _____

Individual/ Guardian Date

_____ _____

Provider Date

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GRIEVANCE PROCEDURE
FOR PARENTS/GUARDIANS AND
PERSON RECEIVING SERVICES/CAREGIVERS

Every person receiving services, caregiver, parent and/or guardian has a right to express a grievance to the center staff. The staff member shall attempt to address the problem.

If the grievance is not addressed to the satisfaction of the person receiving services/caregiver/parent/guardian, he/she may take the complaint to the Program Director.

A grievance form should be filed at this time.

The Program Director shall have 7 days to respond to the filed grievance.

If the grievance is still not resolved to the satisfaction of the person receiving services/caregiver/parent/guardian, he/she may make an appointment to meet with the Program Director.

The Director shall have 20 days to resolve the complaint.

If the grievance is not addressed to the satisfaction of the person receiving services/caregiver/parent/guardian he/she shall then request an appointment with Support Coordinator/Case Manager and/or Liaison, Director; owner/operator. The owner/operator shall have 10 days to resolve this complaint and the decision shall be final.

This form will be reviewed annually

_____ _____

Caregiver signature Date

_____ _____

Director signature Date

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