Our Place Respite Care Center
Admissions Packet

Our Place Respite Care Center is a day program offered by Alzheimer's Alliance Tri-State designed to provide much needed rest and relief for caregivers of persons with Alzheimer's and related dementias and to provide socialization of those living with a diagnosis of Alzheimer's disease.

On specified weekdays from 9 A.M. to 3 P.M., persons with Alzheimer's will be welcomed by trained staff and volunteers into an inviting and home-like environment. They will discover a comfortable, well-lit home away from home comprised of a warm and friendly living room, bright activity area, spacious and welcoming kitchen with a dining area that looks out to a lush walled garden with a peaceful waterfall.

Programming and activities for participants are designed to stimulate cognition and socialization providing a purposeful and rewarding experience with each visit.

CRITERIA FOR ADMISSION

Admission to Our Place Respite Care Center is determined after completion of the following documentation and interview with staff members:

- **Admissions Paperwork includes:**
  - Admissions Application
  - Signed Confidentiality Statement
  - Responsible Party Information
  - Emergency Medical Care
  - Emergency Contact Form
  - Consent/Waiver to Participate in Program
  - Photograph/Video Release

- **Additional Criteria:**
  - Medical care is not administered by respite center staff, therefore, the Client must not require medical treatment such as injections, dressing changes or oral medication administration during the time he/she is at the center.
  - Tobacco products are **not** permitted.
  - Client must be able to toilet him/herself.
  - Client must be ambulatory. Assistive devices such as walkers and/or canes are allowed.
  - Client must be able to feed themselves with little or no assistance.

FEE STRUCTURE & FUNDING GUIDELINES:

When funding is available, Alzheimer's Services is pleased to be able to supplement Our Place Respite Care Center with the Caregiver Assistance Program (CAP) scholarships.

NOTE: An approved application MUST be on file at Our Place for EVERY participant PRIOR to attendance. NO EXEPTIONS!

The fee for participation in the day respite program is a daily rate of $50.00. A statement and invoice will be generated monthly for each day of attendance.

* *Those with Long Term Care Insurance may receive an invoice with the actual days listed for claim reimbursement.*
* *Consideration of greater financial aid for respite care will be made on a one-on-one basis and in accordance with the Caregiver Assistance Program.*

I understand and agree with the fee structure and funding guidelines of the Alzheimer's Alliance Tri-State for Our Place Respite Care Center and the Caregiver Assistance Program.

_____ _____

Caregiver Signature ***Date***

_____ _____

Responsible Party Signature ***Date***

Name of Memory Impaired Person:_____

APPLICATION

Today's Date: _____

Client/Care Receiver Information

Name: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____ **County**: _____

Phone: _____

Date of birth: _____

Marital Status: □ Single □ Married/Domestic Partner □ Widowed

Date of Marriage: _____

Gender: □ Male □ Female

Height: _____ **Weight**: _____ **Eye Color**: _____ **Hair Color**:_____

Client is: □ Right-Handed □ Left-Handed

Is Client a Veteran/Spouse of a Veteran? □ Yes □ No

Race: □ White □ African-American □ Hispanic □ Other

Fluent Languages: □ English □ Spanish □ Other_____

Physician Name:_____ **Physician Phone**:_____

Physician diagnosis: *(select one)*

□ Dementia □ Alzheimer's Disease □ Mild Cognitive Impairment

□ Vascular □ Parkinson's □ Frontal Temporal Lobe Dementia

□ Pick's Disease □ Lewy Body Dementia

□ Other Related Dementia:_____

□ Has not been formally diagnosed; Alzheimer's or other dementia suspected

Approximate year of diagnosis:_____

Which stage did the physician say the client is in or do you think he/she is in?

□ **Stage 1: Mild**	□ **Stage 2: Moderate**	□ **Stage 3: Severe**
Repeating themselves	Confused about recent events	Inability to understand words
Getting lost in familiar places	Not recognizing self in mirror	Difficulty with simple tasks
Losing interest in hobbies	Not recognizing family/friends	Arguing frequently
Forgetting common items	Unable to care for self	Believing things are real that aren't
Personality change	Anxiety and/or depression	Repetitive actions or speech

Does the client live with the primary caregiver? □ Yes □ No

Where does the client reside?

□ Lives alone in house or apartment

□ Lives in house or apartment with others
How many people including client live in house/apartment? _____

□ Lives in a group environment with assistance (not a nursing home)

□ Other: _____

Who referred you to the Alzheimer's Alliance/Our Place Respite Care Center?

_____

Which of the following services are the client and/or family currently using?
(Check ALL services that are used by either the client and/or caregiver)

□ Companion, sitter or friends/neighbors
□ Homemaker/housekeeping services
□ Chore Services
□ Personal Care Services
□ Home Health Services
□ Adult Day Care
□ Transportation services
□ Case Management/Social Worker
□ Support Groups
□ Caregiver Training Programs
□ Psychological counseling
□ Group meals/home delivered meals
□ Respite in a nursing home adult foster home or someone else's home
□ Other service: _____

Client Health and Demographic Information:

Number and type of chronic diseases or physical impairments he/she has *(check all that apply)*:

□ None □ Arthritis □ Diabetes □ Hypertension

□ Heart Disease □ Other

Does the client use any of the following appliances or aids? (Check all that apply)

□ Cane □ Walker □ Wheelchair

□ Hearing Aid □ Eyeglasses □ Dentures
□ Right □ Left □ Upper □ Lower

Does the client have difficulty with food, eating or swallowing? □ Yes □ No

If Yes, please describe: _____

Does he/she follow a special diet? □ Yes □ No

If yes, please describe: _____

Does the client have any allergies? (Includes foods, drugs and environment)

□ Drugs: _____

□ Pollen □ Dairy Products □ Eggs □ Insect Bites □ Sulfa

□ Other: _____

Client Profile

Date: _____

Client Name: _____

Current Caregiver Name: _____

Relationship to client: □ Spouse/Partner □ Child □ Sibling □ Friend □ Other Relative

In continuing our practice of person-centered care, please provide us with some information and personal preferences for your loved one. This information helps us understand your loved one to provide the best possible care.

Thank you so much!

I was born *(where)* _____

Parent's Names _____

Names of Siblings _____

Name of Spouse/Partner _____

Children(s) Names _____

Grandchildren(s) Names _____

Pet's Name _____

Education _____

Work/Occupation _____

I enjoyed the following activities _____

_____

The way I like to awaken and begin my day _____

_____

Continued…

I want my caregivers to know *(things about me)* _____

_____

_____

_____

**Please use the back of this page to add additional history, accomplishments, etc.*

Foods that I enjoy _____

Favorite dessert _____

Things I DO NOT LIKE: _____

_____

I become anxious when _____

_____

Things that calm or soothe me _____

_____

Things that make me laugh _____

_____

Religious Preference *(including church membership)* _____

Preferred Activities *(please check all that apply)*

□ Gardening	□ Arts & Crafts	□ Cooking/kitchen activities
□ Bird watching	□ Music therapy/Singing	□ Dancing
□ Exercise	□ Reading	□ Socials
□ Memory garden walk	□ Spa Day	□ Puzzles
□ Bingo	□ Entertainment	□ Card games
□ Pet therapy	□ Painting	□ Spiritual activities
□ Listening to music	□ Word games	□ Reminiscing activities

□ Other: _____

Our Place Respite Care Center
Admissions Packet

Responsible Party Information

Name: _____

Relationship to Client: _____

Address *(if other than clients)*: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Soc. Sec. #: _____ Date of Birth: _____

Employer Name & Address: _____

_____

I acknowledge responsibility for payment of all fees for Our Place Respite Care Center, a program of the Alzheimer's Alliance Tri-State Area. If for any reason the amount should become delinquent, I am liable to pay for all collection and legal fees.

_____ _____

Responsible Party Date

_____

Printed Name of Responsible Party

Emergency Contact Information

Clients Name: _____ Date: _____

Please list at least two people we can contact in case of emergency.

Emergency Contact #1

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Cell Phone: _____

Emergency Contact #2

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Cell Phone: _____

Optional Emergency Contact

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Cell Phone: _____

Confidentiality Agreement

Information contained in the files/records of Our Place Respite Care Center, a program of the Alzheimer's Alliance Tri-State Area, is confidential.

All employees and volunteers are required to sign a confidentiality agreement.

How we may use and disclose information about respite center clients

In some circumstances we may use or disclose information about a client's participation in the programs at the respite care center.

These circumstances include:

1. **To obtain emergency medical treatment**
2. **Fundraising Activities**
   We may contact you as part of our effort to raise funds for Alzheimer's Alliance Tri-state Area. We will use your photo or information with your written permission.
3. **As required by law**
   We will disclose information about clients when required to do so by federal, state or local law.
4. **To avert a serious threat to health or safety**
   We may use and disclose information about clients when necessary to prevent a serious threat to his/her health and safety or the health and safety of the public or other person(s). Any disclosure, however, would only be to someone able to help prevent the threat.
5. **Public Health risks**
   We may disclose information about clients for public health activities. These activities generally include the following:
   a. To prevent or control disease, injury or disability
   b. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
   c. To notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence
6. **Health Oversight Activities**
   We may disclose health information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
7. **Law Enforcement**
   We may release client information if asked to do so by a law enforcement official:
   a. In response to a court order, subpoena, warrant, summons or similar process
   b. To identify or locate a suspect, fugitive, material witness, or missing person
   c. About the victim of a crime, if, under certain limited circumstances, we are unable to obtain the persons agreement
   d. About criminal conduct at the organization
   e. In emergency circumstance to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

You have the right to:

1. Request confidential communications
   For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.
2. A paper copy of this notice
   You will be given a copy of this notice upon acceptance in to Our Place Respite Care Center, a program of the Alzheimer's Alliance Tri-State Area.

I understand and agree with the confidentiality agreement for Our Place Respite Care Center, a program of the Alzheimer's Alliance Tri-State Area.

_____ _____

Caregiver Signature ***Date***

_____ _____

Responsible Party Signature ***Date***

Participation Consent & Waiver

I/we, the undersigned, do hereby agree to participate in the programming of the Our Place Respite Care Center, a program of the Alzheimer's Alliance Tri-State Area.

I/we, the undersigned, do hereby expressly remiss, release, and forever discharge the Alzheimer's Alliance Tri-State Area and all of its administrators, other employees, acting officially or otherwise, from any and all claims, demands, actions, or causes of actions, on account of death, or on account of injury to the undersigned, my/our heirs or assigns, which may occur as a result from said services and duties to be performed by Our Place Respite Care Center, a program of the Alzheimer's Alliance Tri-State Area.

I/we understand that Our Place Respite Care Center, a program of Alzheimer's Alliance Tri-State Area, will re-evaluate clients every 6-8 weeks to determine ability to participate in the programming provided at Our Place Respite Care Center.

I understand that my participation in Our Place Respite Care Center, a program of the Alzheimer's Alliance Tri-State Area, will be DISCONTINUED if my circumstances change.

_____ _____
Client/Legal Guardian Signature Date

_____ _____
Alzheimer's Alliance Executive Director or Respite Center Coordinator Date

Photography/Video Release Form

Date: _____

Client Name: _____

I hereby give to Our Place Respite Care Center, a program of the Alzheimer's Alliance Tri-State Area, it's nominees, agents and assigns, my free and unlimited consent and permission, waiving all claims for any compensation by reason thereof or for damages by reason thereof, to use, publish/broadcast, republish/rebroadcast or exhibit in the furtherance of its work, with or without identification of me by name, the photograph/video below:

Alzheimer's Alliance Tri-State Area and Our Place Respite Care Center Photography

To disseminate statements referring to me in conjunction therewith if Alzheimer's Alliance Tri-State Area so desires to authorize any media, company or organization to use, publish/broadcast or exhibit said photograph/video with or without identification of me by name and to publish/broadcast or disseminate statements referring to me in conjunction therewith in the promotion of Alzheimer's Alliance Tri-State Area and any of its fundraising campaigns or any of its clients.

_____
Signature

Name: _____
(Please print)

Address: _____

Phone: _____
Work/Home Cell

If the individual photographed/videotaped is a minor (under 18 years of age), a parent or legal guardian should sign the following:

I hereby consent and agree, individually and as a parent or legal guardian of _____ (a minor) to all the terms and provisions stated above.

Witness my signature this _____ day of _____ of the year _____.

_____ Relationship to minor: _____
Signature

Address/Phone(s):_____

Additional Services & Direction

What other information would be helpful to you?

Please rate your interest in attending an educational workshop on each of the following topics:
1 – No interest *2 – A little interest* *3 – A great deal of interest*

Incontinence Care	1	2	3
Adaptive equipment (clothing, special utensils, etc.)	1	2	3
Nutrition and dietary concerns	1	2	3
Managing problem behavior	1	2	3
Other: _____	1	2	3

Do you have interest in attending a caregiver's support group? □ Yes □ No

If so, which time do you prefer? _____ Daytime _____ Evening

Consent for Emergency Medical Care

I hereby grant permission to the staff of Our Place to obtain emergency medical care for _____ if needed. I understand that, in case of emergency, the participant will be transported by ambulance to the nearest medical facility providing emergency care and treatment. I also understand the cost of emergency medical care is the responsibility of the participant/ responsible party.

Emergency Contact_____

Phone_____

Cell Phone_____

Alternate Emergency Contact_____

Phone_____

Cell Phone_____

When possible, I would like participant to be transported to

Wadley____

Christus St. Michael____

Other_____

Signature of Participant or Authorized Representative

_____ Date_____

Witness/ Staff Signature

_____ Date_____

Medication List

From "Friends" at Our Place
Alzheimer's Alliance Tri-State
100 Memory Lane
Texarkana, TX 75503

Friend_____

Emergency Contact_____

Phone_____

Medications as of _____ 2017

Medication	Dosage	Frequency