ReGenerations Adult Day Club

Admission Packet

Instructions

1. Please print out the forms and fill them out completely. We ask that a family member or close friend assist the club member in completing these forms.

2. This information is extremely helpful in providing the most effective program. In addition, it will help us provide activities that are of interest to the club member. Some of the questions may not pertain to the member, if this is the case, please write "N/A" (not applicable) in the space.

3. Club member must receive a 2-step Tuberculosis test and a physical exam. Results from both, and medical record history, must be turned in before the first day of attendance.

4. A Referral/Prescription Request Form (page 15) must be signed by the club member's primary care doctor and returned. This can be faxed by ReGenerations staff if needed.

5. After completing this packet, you may fax, mail, or bring the packet to The Club (Attention: Christina Reynolds). Thank you for your cooperation. This information will be kept confidential.

Paperwork Needed to Begin the Club:

- ☐ Completed Admission Packet
- ☐ 2-step Tuberculosis Test Results (with results and read dates)
- ☐ Physical Exam Results (within the last 6 months)
- ☐ Medical History
- ☐ Referral/Prescription Request Form

ReGenerations Club

NEW CLUB MEMBER INFORMATION SHEET

CLUB MEMBER NAME____
LAST FIRST MI

PHYSICAL ADDRESS____
STREET CITY STATE ZIP

BILLING ADDRESS____
STREET CITY STATE ZIP

EMAIL ADDRESS____

Please indicate if you want all correspondence from The Continuum sent in a sealed envelope marked "Confidential" Yes ( ) No ( )

PRIMARY CONTACT NAME: ______________________ RELATIONSHIP: _________________

PHONE NUMBER ( ) _________________ ( ) ________________ ( )_______________
HOME CELLULAR OTHER

Please indicate the telephone number where you want to receive calls about your appointments, billing questions, or other healthcare questions____.

Please note that we will use this number to leave messages regarding the above if there is no answer.

DATE OF BIRTH: ____ /____ /____ SSN: _________________________ MALE ( ) FEMALE ( )

PRIMARY OCCUPATION: ________________________ RACE: _________________________
(PRIOR TO RETIREMENT)

RELIGION: _________________________ MILITARY AFFILIATION: ____________________

DIET/FOOD RESTRICTIONS: ____

PRIMARY DIAGNOSIS: ____

PHYSICIAN/HOSPITAL/EMERGENCY

Club member or primary caregiver shall designate a physician/hospital to be called in case of an emergency. ReGenerations staff shall have the right to seek emergency treatment from paramedics should the need arise and the designated physician is unavailable.

PRIMARY CARE DOCTOR: ____

ADDRESS: ____

PHONE: __________________________________ FAX: ___________________________________

HOSPITAL: ____ POSLT/DNR: Yes ( ) No ( )

Please list the family members or significant others, if any, whom we may inform about emergencies.

NAME: ____ PHONE ( )__________-_________

NAME: ____ PHONE ( ) _________ -_________

NAME: ____ PHONE ( ) _________ -_________

ADDRESSES OF NEXT OF KIN OR GUADRIANS NOT IN RESIDENCE:

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Admission Criteria for ReGenerations Club

Pursuant to Title VI of the Civil Rights Act of 1961, ReGenerations Club is nondiscriminatory. Religion, race, national origin, alienage, disability, age or sex will not be considered in the admission process or treatment following admission.

- **A physical examination** conducted by a physician (M.D., P.A., or Nurse Practitioner) within the last six months is required prior to admission into ReGenerations Club. The updated physical results, along with a **complete medical history** and any dietary restrictions must be provided **before the first attendance day.**

- **A 2-step Tuberculosis (TB) test is required before the first day of attendance.** A Quantiferon Blood Test can be substituted for a 2-step TB Test. A 1-step TB test is required every year after admission. Staff will send reminders when annual date is near.

- In regard to TB, club members must not have any of the following symptoms:
    - A cough for more than 3 weeks
    - A cough which is productive
    - Blood in the sputum
    - A fever which is not associated with a cold, flu or other apparent illness
    - Experiencing night sweats, unexplained weight loss, or has been in close contact with a person who has active tuberculosis

- Club member should be continent of bowel and bladder and require minimal staff assistance with toileting. Members requiring more assistance will be taken on a case-by-case basis.

- Club members should not be considered dangerous to self or others. Members engaging in disruptive behavior are subject to dismissal from the program.

- Dismissal can result from a club member that demonstrates consistent behaviors such as: behaviors that could result in physical harm to self or others, consistent disruptive behaviors that result in agitation of other club members, club member's physical decline has resulted in having one-on-one supervision, and/or wandering behavior that cannot be redirected.

- Behaviors resulting in any of the above will be documented and if possible, strategies will be implemented to deter behaviors. Staff will work with family and health care provider when indicated. Family/caregiver will be notified of issues and concerns.

- Club member must be able to communicate his or her needs to ReGenerations staff either verbally, written, or through gestures; and club member must not require any form of restraint or sedative unless ordered by a physician.

- Club member or primary caregiver is responsible for arranging transportation to and from ReGenerations Club. Club members **MUST** be picked up from the Club no later than 5:30 pm. RTC Access rides must not be scheduled for later than 5:00 pm.

- Club member or caregiver is responsible for providing proper daily dosage of medication taken while at ReGenerations Club. Member will self-administer medication. ReGenerations will have a secure area for medications and can remind members when it is time for medications.

- Club member or caregiver is responsible for informing ReGenerations staff if they are unable to attend on a scheduled day. Members who frequently cancel without prior notification are subject to dismissal from the club. **There will be a $10 charge for no call, no shows on scheduled days.**

- Club members are served a meal for lunch, meeting 1/3 of the RDA requirements. Any ReGenerations member remaining in the facility longer than 6 hours will be provided with extra nourishment. Depending on dietary restrictions, ReGenerations staff will also provide extra nourishment as required or requested by members.

Illness Policy

- Club members are not permitted to attend The Club if they have had a fever in excess of 100°F, uncontrollable diarrhea or vomiting within the previous 48 hours.

- Responsible party agrees to notify staff immediately if club member or caregiver are exposed to or contract a communicable disease.

- Responsible party also agrees to pick up or arrange for transportation if club member becomes ill while at The Club.

Standard Admission Waiver

The management of this program has agreed to exercise such responsible care toward this person as his or her own condition may require, however, ReGenerations Club is in no sense an insurer of his or her safety or welfare and assumes no liability as such.

The management of ReGenerations Club will not be responsible for any valuables or money left in the possession of members while he or she is active in the Club.

____ ___________________
Club Member Name Date

____ ___________________
Member/Caregiver/Guardian Signature Date

____ ___________________
Christina Reynolds Date
ReGenerations Director

ReGenerations Financial Agreement

The fees are as follows:

$63.00 Full day with Lunch

$45.00 Half Day with Lunch**

$40.00 half Day without Lunch**

**The half day program hours are: 7:30 am to 1:00 pm or 12:00 pm to 5:30 pm.

A $75.00 registration and processing fee will be paid upon completion of a pre-admission interview.

We are committed to your experience being successful. Please understand that payment of your bill is considered a part of the Adult Day Club. The following is a statement of our Financial Policy, which we require you to read and sign prior to Adult Day Club services.

Payment Policy: Monthly statements are mailed the 1st business day of the following month. Payment is due within 30 days.

I understand that ReGenerations Club is billed on a day-to-day basis, therefore I will be charged according to each day of attendance. I agree to pay The Continuum upon receipt of their statement. I understand that the financial responsibility is mine. I also understand that if club member is not going to attend The Club on a scheduled day then I must **call by 9 am** that morning or I will be billed **a $10.00 no call/no show fee.**

I have read and understand the Adult Day Club payment policy.

____ ________________________
Club member Name Date

____ ________________________
Caregiver/Guardian/Person Responsible for Charges Date

____ ________________________
ReGenerations Director Date
Christina Reynolds

Financial Assistance Options

- Alzheimer's Association Grant – Requirements include 65+ age, primary diagnosis of a memory disorder, and caregiver must live with the recipient.
  - Recipient receives $250 per quarter
  - Stephanie Wardell.. 775.786.8061

- Elvirita Lewis Respite Program – Requirements include 60+ age and a medical or physical diagnosis.
  - Recipients receive $1,000 per year
  - Mary Brock.. 775.358.2322

- Home and Community Based Waiver Program – Requirements include: 65+ age, Medicaid recipient or Medicaid eligible, income less than $2,094 per month, assets less than $2,000, and must require assistance with personal care.
  - Stephanie Allen.. 775.687.0840

- Independent Living Grant (ADSD) – Requirements include populations who are frail and may be at risk if unsupervised, 60 years and older, declining due to isolation, would benefit from a stimulating and social environment which could prevent or delay institutional placement, caregiver would benefit from some time away from their care recipient, and financially at risk.
  - Christina Reynolds... 775.221.8052

- Nevada's Community Options Program for the Elderly (COPE) – Requirements include 65+ age, legal Nevada resident, be at risk of institutionalization (nursing home placement) if services are not provided, and monthly income must be greater than $2,199 (Medicaid limit) but less than ($3,100) with countable assets of $10,000 or less.
  - State of NV Aging and Disability... 775.688.2964

- VA Grant – Requirements include being enrolled at the VA.
  - Nancy Graham.. 775.829.5679

- Veteran's Aid and Attendance – Requirements include 65+ age, the "Aid and Attendance" of another person, and service of at least 90 days of active duty with at least 1 day during a time of war.
  - A veteran may receive up to $1,732 per month, a married couple up to $2,054, and a surviving spouse may receive up to $1,113 per month.
  - Melissa Hartman... 775.853.5700

Privacy Disclosure

The Continuum offers a variety of activities throughout the month for you and/or the club member to enjoy. Due to the recent implementation of the Health Insurance Portability and Accountability Act (HIPAA), we want to inform you that many people from the community will be in The Club for your enjoyment and entertainment. We provide each club member with a calendar at the beginning of each month so that you may be prepared for each activity.

It is necessary that you sign a Privacy Disclosure acknowledging your awareness of our activities.

- ☐ I am aware that The Continuum arranges many activities that may involve different members of our community and I am aware that they have signed confidentiality statements disclosing that they may not discuss or repeat any personal information they may hear while visiting The Continuum.

- ☐ I wish to be notified whenever a scheduled or non-scheduled member of our community is to attend ReGenerations whether to perform or help with a scheduled activity.

If you choose to be notified, please fill in the following information:

___________________________________	_____________________________________
Phone Number	Best time to call
___________________________________	_____________________________________
Club Member Name	Member/Caregiver/Guardian Signature

Consent and Release for Photography, Video and/or Audio Taping

☐ I authorize The Continuum to photograph, video/audio tape
Club member which **may** be used for marketing purposes, and/or The Continuum's Facebook page.

☐ I **do not** authorize The Continuum to photograph, video/audio tape
Club member for marketing purposes, and/or The Continuum's Facebook page.

***We understand the importance of privacy in the lives of the people ReGenerations Club supports. However, standard procedure during new club member orientation is to develop an I.D. Badge for them while they are at The Club. A picture will be taken of them for this purpose. ***

____
Club Member Name

____ ______________________
Member/Caregiver/Guardian Signature Date

Social History

General Information:

Married: ___________ Date: ________________ Single: ______________ Divorced: __________

Widowed: __________ Date: ________________

Name of Spouse: ____________________________ Parents' Names: ____________________________

Are parents living: ____________________________ If so, where: _______________________________

Place of Birth: ______________________________ States/Countries lived in: ____________________

Travel Experience: ____

School and Work History:

Schools attended/Grade School, High School: ____

____

College: ____

Degrees: ____________________________ Favorite subjects in school: _________________________

Work History: ____

Date of Retirement: _______________ Speak more than one language? _________________________

Does club member do any writing? _______________ Does club member read? __________________

Kinds of books? __________________ Magazines? _______________ Newspaper? ______________

Personal Interests:

Hobbies/Interests: ____

Outdoor Recreation: __________________________ Indoor Recreation: _________________________

Play any musical instruments: _______________ Other skills/talents (art, typing, sports, singing, etc.):

____

Clubs/Organizations/Church memberships: ____

____

Family Goals and Information:

Family's impression of major strengths: ____

____

What are the goals of the club member? ____

____

If applicable, what type of positive reinforcement may motivate club member? ____________________

____

Any topics of conversation to be avoided? ____

____

Reaction of friends and relatives since onset: ____

____

Club Member's Children and Grandchildren:

Name	Nickname	Relationship	City, State

Other Close Relatives:

Name	Nickname	Relationship	City, State

Close Friends/associates (neighbors, church, co-workers, etc.):

Name	Nickname	Relationship	City, State

Medical Information:

Primary Diagnosis: ____________________________ Approx. Date of Onset: ____________________

Describe any major illnesses or accidents in addition to primary diagnosis: ______________________

____

Personality characteristics prior to onset (outgoing, shy, social, etc.): __________________________

____

Personality characteristics since onset: ____

____

Is club member continent? Yes/No_____________ Daytime: _____________ Nighttime: _________

Does club member wear glasses? Yes/No________ Reading? ____________ All the time? _______

Does club member have hearing loss? Yes/No______ Right Ear? _______ Left Ear? _______ Both Ears? ______ Hearing Aid? _______ Wear dentures? Yes/No____ Partial? ____ Complete? ______

Food Preferences: ____

____

Food Allergies: ____

____

Diet Restrictions: ____

Other Allergies: ____

Medications: ***Please notify us if there are any changes we may need to know about***

Name	Taken for	#Taken	Times per day	Date begun

Referral/Prescription Request

This form must be signed by club member's physician (M.D., P.A., or Nurse Practitioner)

Date: ____

Patient's Name: _____________________________________

Date of Birth: _______________________________________

Please mark which rehabilitation services are being prescribed for the patient:

- ❑ Adult Day Services: ReGenerations Adult Day Club
- ❑ Speech- Language Therapy
- ❑ Occupational Therapy
- ❑ Physical Therapy

In regard to Adult Day Services, I certify that I have reviewed the health history and examined this person and found him/her to be free of communicable/contagious diseases and is presently in good health, not lacking in stamina and capable of attendance as a member in an adult day care setting for five (5) or more hours.

Dr. Signature ____

Printed Name ____

Please contact ReGenerations Adult Day Club with any questions or concerns regarding this patient. We appreciate your willingness to assist us in the provision of comprehensive care.

Thank You,

Christina Reynolds
ReGenerations Adult Day Club Director

Physical Examination Report

This form must be completed and signed by the club member's physician (M.D., P.A., or Nurse Practitioner) and returned to ReGenerations Adult Day Club **prior to admission**.

Name: __________________________ Birthday: _________________ Today's Date _____________

Primary Diagnosis: ____

Blood Pressure: ____________ Pulse: ______________ Resp: ______________ Weight: _____________

Please list any conditions that might restrict Club Member's activities or require special attention at ReGenerations Adult Day Club (physical, emotional, mental, immune system, contagious illness, allergies, special equipment, dietary restrictions, etc.)

I certify that I have reviewed the health history and examined this person and found him/her to be free of communicable/contagious diseases and is presently in good health, not lacking in stamina and capable of attendance as a member in an adult day care setting for five (5) or more hours.

Physician Signature: ____ Date**:** ________________________

Free Falls Prevention Screening Consent

According to the U.S. Centers for Disease Control and Prevention:

- One-fourth of Americans aged 65+ fall each year.
- Every 11 seconds, an older adult is treated in the emergency room for a fall; every 19 minutes, an older adult dies from a fall.
- Falls are the leading cause of fatal injury and the most common cause of nonfatal trauma-related hospital admissions among older adults.
- Falls result in more than 2.8 million injuries treated in emergency departments annually, including over 800,000 hospitalizations and more than 27,000 deaths.
- In 2013, the total cost of fall injuries was $34 billion.
- The financial toll for older adult falls is expected to increase as the population ages and may reach $67.7 billion by 2020.

By signing this document, I am consenting to take part in a Free Falls Prevention screening during attendance at ReGenerations.

____

Club Member Name

____ ______________________

Member/Caregiver/Guardian Signature Date