ReGenerations Adult Day Club

Admission Packet

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.

NAME: _____
DATE: _____

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 17) must be signed by the club member's primary care doctor and returned.

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 REGENERATIONS:

☐ Completed Admission Packet

☐ 2-step Tuberculosis Test/Quantiferon Blood Test Results (with results and read dates)

☐ Physical Exam Results (within the last 6 months)

☐ Medical History

☐ Referral/Prescription Request Form

NAME: _____
DATE: _____

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

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

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

PRIMARY OCCUPATION: _____ RACE: _____
(PRIOR TO RETIREMENT)

RELIGION: _____ MILITARY AFFILIATION: _____

DIET/FOOD RESTRICTIONS: _____

PRIMARY DIAGNOSIS: _____

CARE PARTNER CONTACT NAME: _____ RELATIONSHIP: _____

PHONE NUMBER ( ) _____ ( ) _____ ( ) _____
HOME CELLULAR OTHER

Please indicate the telephone number where you want to receive calls/messages regarding your appointments, billing questions, or other healthcare questions. ( ) _____

CARE PARTNER EMAIL ADDRESS:_____

NAME: _____
DATE: _____

REGENERATIONS EMERGENCY PLAN

Club member or care partner 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: _____ RELATIONSHIP: _____ PHONE ( ) _____-_____

NAME: _____ RELATIONSHIP: _____ PHONE ( ) _____-_____

NAME: _____ RELATIONSHIP: _____ PHONE ( ) _____-_____

ADDRESSES OF NEXT OF KIN OR GUARDIANS NOT IN RESIDENCE:

_____

_____

_____

_____

_____ _____

Member/Care Partner/Guardian Signature Date

NAME: _____
DATE: _____

REGENERATIONS CLUB POLICIES

- **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 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 care partner and health care provider when indicated. Care partner 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.

NAME: _____
DATE: _____

- Club member or care partner 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 care partner 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 care partner 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 or 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.

- Care partner agrees to notify staff immediately if club member or care partner are exposed to or contract a communicable disease.

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

_____ _____
Member/Care Partner/Guardian Signature Date

_____ _____
Christina Reynolds – ReGenerations Director Date

NAME: _____
DATE: _____

REGENERATIONS STANDARD ADMISSION WAIVER

The management of this program has agreed to exercise such responsible care toward **Club Member: _____** 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/Care Partner/Guardian Signature Date

_____ _____
Christina Reynolds Date
ReGenerations Director

NAME: _____
DATE: _____

REGENERATIONS FINANCIAL AGREEMENT

The fees are as follows:

$70.00 Full day with Lunch

$50.00 Half Day with Lunch**

$45.00 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 ReGenerations Club. The following is a statement of our Financial Policy, which we require you to read and sign prior to ReGenerations 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.

I have read and understand the ReGenerations Club payment policy.

_____ _____
Club member Name Date

_____ _____
Care Partner/Guardian/Person Responsible for Charges Date

_____ _____
Christina Reynolds - ReGenerations Director Date

NAME: _____
DATE: _____

FINANCIAL ASSISTANCE OPTIONS (1 OF 2)

- **Alzheimer's Association Grant** – Requirements include a primary diagnosis of a memory disorder, and caregiver must live with the recipient. **(No age requirement)**
  - 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.
  - Kirstin Hudson…….. 775.785.7108

NAME: _____
DATE: _____

FINANCIAL ASSISTANCE OPTIONS (2 OF 2)

- **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

- **Seniors in Service** – Requirements include 60+ age, care receiver has a functional impairment that necessitates someone to provide for safety and well-being in order to remain living at home, care receiver needs supervision and/or hands on assistance with most ADL's, care receiver has a family member, friend or other unpaid caregiver as primary caregiver to maintain safety and wellbeing and caregiver must reside in the same residence as the care receiver.
    - Seniors in Service …… 775.358.3914

NAME: _____
DATE: _____

ReGenerations Privacy Disclosure

The Continuum offers a variety of activities throughout the month for the club members to enjoy. Due to the Health Insurance Portability and Accountability Act (HIPAA), we want to inform you that many people from the community will be in ReGenerations 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.

_____ _____
Phone Number Best time to call

_____ _____
Club Member Name Member/Care Partner/Guardian Signature

_____
Date

NAME: _____
DATE: _____

REGENERATIONS PHOTOGRAPHY, VIDEO AND/OR AUDIO TAPING CONSENT AND RELEASE

☐ 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 ReGenerations. A picture will be taken of them for this purpose. ***

_____
Club Member Name

_____ _____
Member/Care Partner/Guardian Signature Date

NAME: _____
DATE: _____

REGENERATIONS SOCIAL HISTORY (1 OF 3)

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? _____

NAME: _____
DATE: _____

REGENERATIONS SOCIAL HISTORY (2 OF 3)

Personal Interests:

Hobbies/Interests: _____

Outdoor Recreation: _____ Indoor Recreation: _____

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

_____

Clubs/Organizations/Church memberships: _____

_____

Any additional information that may be helpful to staff:

_____

_____

_____

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: _____

_____

NAME: _____
DATE: _____

REGENERATIONS SOCIAL HISTORY (3 OF 3)

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

NAME: _____
DATE: _____

ReGenerations 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: _____

Swallowing Issues: _____

Is club member a fall risk? Yes/No _____

NAME: _____
DATE: _____

REGENERATIONS 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
The Continuum

NAME: _____
DATE: _____

REGENERATIONS 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.)

Medications (or please attach):

Name	Taken for	#Taken	Times per day	Date begun

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: _____

Printed Name: _____ Phone: _____