

# 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. **Before the first day of attendance, club members must receive and provide proof of a 2-step Tuberculosis test or Quantiferon blood test, the COVID-19 vaccine, a physical exam, and a brief medical history.**
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 or Quantiferon Blood Test Results (with results and read dates)
- COVID-19 Vaccination Record
- Physical Exam Results (within the last 6 months)
- Medical History and any dietary restrictions
- 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: \_\_\_\_\_

## 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
  
- 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
  
- 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



NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## FINANCIAL ASSISTANCE OPTIONS (2 OF 2)

- 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 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 with lunch 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 1<sup>st</sup> business day of the following month. Payment is due within 30 days. Club membership may be suspended for non-payment.

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

\_\_\_\_\_  
Anne Pott - ReGenerations Director

\_\_\_\_\_  
Date



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 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)

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**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,

Anne Pott  
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 a list):

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 a day.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_



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: \_\_\_\_\_

Veteran Status: \_\_\_ Branch: \_\_\_\_\_ Rank: \_\_\_\_\_ Position/s: \_\_\_\_\_

Service Era: \_\_\_\_\_ Locations: \_\_\_\_\_

Service-connected exposures/injuries/conditions:

\_\_\_\_\_

Comfort level in talking about service 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## REGENERATIONS CLUB POLICIES

- **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
- **A copy of the COVID-19 vaccination record is required before the first day of attendance.**
  - **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.**
  - 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.



NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

- 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 care partner is responsible for arranging transportation to and from ReGenerations Club. Club members **MUST** be picked up from the Club no later than 5:00 pm. **RTC Access rides must not be scheduled for later than 4:30 pm to ensure pick-up at 5 p.m.**
- 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.



NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## 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.
- Club member or 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

\_\_\_\_\_  
Anne Pott – ReGenerations Director

\_\_\_\_\_  
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

\_\_\_\_\_  
Anne Pott - ReGenerations Director

\_\_\_\_\_  
Date





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/Regenerations' Facebook and/or Instagram 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: \_\_\_\_\_

## QUESTIONS: