Welcome!

Welcome to CarePartners Dementia Day Center. We are excited that you are considering our services and we hope we are able to meet your needs. To begin enrollment, please complete this enrollment packet to the best of your ability. If you are unsure of a question, do not let this discourage you. You may contact a staff member for clarity.

In this packet you will find a Physician's Orders form. This form must be completed by a doctor and should state a diagnosis of dementia or a related disease that causes memory impairment. We also require that members have a TB skin test within the last year. You may elect to have the physician fax the results and Physician's Order form to the Day Center upon completion, However, the form and the TB skin test must be done before a member may enroll at the Center.

Please complete the following packet to begin the enrollment process. We are available to answer any additional questions or provide further information. Again, welcome to CarePartners Dementia Day Center!

Andrea Williams, MPH
Director

Ade Odimayo
Nurse

Tyra Hunter
Activity Director

CarePartners Dementia Day Center

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713.682.5995
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www.carepartners.org

Enrollment Check List

Thank you for considering CarePartners Dementia Day Center. We look forward to having you and your family joining our organization. We hope to make the transition an easy one and have provided a check list below to help you with the enrollment process. Please do not hesitate to call if you have any questions.

1) ___ Please review the Family Policies and Procedures Handbook and complete the enrollment forms included in this packet. Please sign and date all forms prior to the enrollment appointment.

2) ___ Complete a Tuberculosis (TB) test or provide record of results if tests were performed within the last year.

3) ___ Submit Physician's Orders form to physician or nurse practitioner (Form is provided in the enrollment packet). Please ensure the form is faxed back to 877.795.2696.

4) ___ Call 713.682.5995 or email daycenter@CarePartnersTexas.org to schedule an enrollment appointment when all the above is complete.* Enrollment appointments typically last 1 hour. If any of the above items are not completed prior to the enrollment appointment, the appointment will be rescheduled.

Please note the following:

- The Physician's Orders form and TB Skin Test must be completed and submitted to the Day Center prior to the enrollment appointment.
- The Enrollment Forms must be completed prior to the enrollment appointment. If the forms are not completed, you may be asked to reschedule your appointment.
- The potential Day Center member will need to be assessed at the scheduled enrollment appointment so both the primary caregiver and potential member must attend.
- Enrollment times are limited to Mondays, Wednesdays, and Fridays at 10:00am and 3:00pm. Appointments are made on a first come, first served basis and contingent on the Day Center staff's availability.

Member Initials:___

Enrollment Forms

Member Initials: _

Day Center Admission Form

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Demographic Information

Birth Date:	**Age:** **Gender:**	**Veteran** (circle one): **Yes No**

Racial/Ethnic Background: _____ **Marital Status:** _____

Member's Monthly Income: *(Collected for statistical purposes only.)*

Monthly Household Income: *(Collected for statistical purposes only.)*

Current Home Environment:

Lives with: _____ Number in Household: _____

How does the individual feel about attending the Day Center?

_ Accepting _ Complacent _ Angry _ Doesn't Comprehend
_ Depressed _ Unaware _ Bitter _ Other: _____

Planned Mode of Transportation to/from center:

__Private Auto __Transportation Provider (list provider):

Primary Contact Information

Name: _____ Relationship to Member: _____

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Is the billing contact different from the Primary Contact? _____Yes _____No

If Yes, please provide his or her contact information below:

Name _____ *Relationship to Member:* _____

Mailing Address: _____

Email Address: _____

Phone Number: _____

Member Initials: _____

Biographical Information

Family

Where was childhood spent: _____

Number and names of siblings:

_____

Number still living: ____

Spouse's Name (if applicable): _____ Is spouse living: ___Yes___No

Number and names of children: _____

_____

Number still living: ____

Number of grandchildren: _____ Number of great grandchildren: _____

Comments: _____

_____

Highest Education Achieved *(i.e. high school, graduate school, no formal schooling)* : _____

Comments: _____

_____

Military Service *(i.e. Army, Marines, Coast Guard, Air Force, Navy):* _____

Comments *(Include rank if applicable):* _____

_____

Former Occupation(s): _____ .Last Employer: _____

Comments: _____

_____

Religious Preference: *(i.e. Christian, Jewish, Atheist, Buddhist):* _____

Comments: _____

_____

Primary Language(s): _____

Secondary Language(s) *(If any):* _____

Member Initials: _____

Additional Background Information

Please provide as much detail as possible to the following questions. Your answers will help us to better understand your loved one's history. If **more space is needed, please attach additional pages.**

1. Please describe your loved one's present home environment and his or her role in the family dynamic. Include all family members and a description of your loved one's relationship with them.

_____

_____

_____

_____

2. Describe your loved one's typical day. Include favorite activities and regularly scheduled appointments.

_____

_____

_____

_____

3. Describe any major life changes that have occurred in the past year with your loved one or any that you expect to occur in the near future.

_____

_____

_____

_____

4. Describe anything that causes your loved one anxiety. Include your typical response to their anxiety and any ways that you normally deal with these situations.

_____

_____

_____

_____

5. Please describe your loved one's preferred social setting. (i.e. *small group, one-on-one, large group; please note anyone he or she may feel uncomfortable with)*

_____

_____

Member Initials:_____

Caregiver Information

CarePartners is required to collect demographic information on the people who benefit from day center services, including family caregivers receiving respite.Please complete the caregiver information requested as completely as possible. *The information requested in italics is for statistical purposes only and will not affect your service.* **All information will remain confidential.**

Primary Caregiver Contact:

Name:_____Relationship:_____

Address:_____ City:_____Zip:_____

Home Phone:_____Work Phone:_____Cell:_____

Employer:_____Military Status: _Veteran _Active Duty _*NIA*

May contact regarding billing? _Yes _ No May contact regarding care? _ Yes _ No

DOB: _____*Sex:* ___ *Race:* _____ *Marital Status:*_____

*Monthly Income:*_____ *Lives with Member?*___Yes ___No

Secondary Caregiver Contact:

Name:_____Relationship:_____

Address:_____City:_____Zip:_____

Home Phone: _____ Work Phone: _____Cell: _____

Employer:_____Military Status: _Veteran _Active Duty _*NIA*

May contact regarding billing? _ Yes _ No May contact regarding care? _ Yes _ No

DOB: _____*Sex:* __ *Race:*_____*Marital Status*_____

*Monthly Income:*_____ *Lives with Member?*_____Yes_

_____No

Third Caregiver Contact:

Name:_____Relationship:_____

Address:_____City:_____Zip:____ _

Home Phone:_____Work Phone:_____Cell:_____

Employer:_____Military Status:___Veteran ___ Active Duty _*NIA*

May contact regarding billing? _ Yes _ No May contact regarding care? _ Yes _ No

*DOB:*_____*Sex:*____ *Race:*_____*Marital Status:*_____

*Monthly Income:*_____ *Lives with Member?* _Yes _No

Member Initials:_____

Emergency Contact Information

Please give the name, relationship, & phone number of the person(s) to be contacted if caregiver(s) cannot be reached in case of an emergency. **We require at least 3 contacts including the caregivers listed earlier.** You do not need to list caregivers again. Please make sure that all individuals listed are notified that they are on this list.

	Emergency Contact	Relationship to Member	Phone Number(s)
1.			
2.			
3.			
4.			
5.			

I hereby authorize CarePartners Dementia Day Center to allow my family member to leave the facility ONLY with the above-named people other than his/her listed caregiver(s). They will be asked to provide a valid form of identification.

_____ _____

Signature of Caregiver/Responsible Party **Date**

Member Initials: _____

Member Interests

The following information enables us to understand your loved one's interests better. Please rate your loved one's interest in the following activities from 1 to 5. If he or she is not interested at all, you may leave it blank.

1=Interested once in a while **5=Always enjoys the activity**

EXAMPLE: *__5__ Church Services (always wants to participate)*
__1__ Dancing (will dance upon occasion)
____ Card Games (never plays cards)

___ Art appreciation
___ Art work (drawing or painting)
___ Arts and Crafts
___ Bible/devotional reading
___ Church Services
___ Conversation or discussion with peers
☐ Cooking
☐ Sewing
☐ Domestic Chores (sweeping, folding clothes, etc.)
☐ Crocheting
☐ Knitting/Needlework
☐ Electronics
☐ Movies
Favorites:_____
_____
_____
☐ Exercise or fitness routines
☐ Gardening (including house plants)
☐ Woodworking
☐ Home decorating
☐ Travel

___ Collection (coins, stamps, etc.)
☐ Singing
☐ Dancing
☐ Listening to Music
Favorites:_____
_____
_____
☐ Outings
___ Community events
___ Antique shops
___ Museums
___ Nature trails
___ Other
☐ Trivia Games
☐ Word Games (word search, crossword puzzles, etc.)
☐ Table games
☐ Puzzles
☐ Casino Games
☐ Dominoes
☐ Bingo
☐ Card Games
Describe: _____
☐ Pets: _____
☐ Picnics
☐ Volunteering

☐ Play a Musical Instrument
Describe: _____
_____
_____
☐ Reading
___ Magazines
___ Books
___ Poetry
___ Newspaper
☐ Writing
☐ Sports
Favorites: _____
_____
_____
☐ Fishing
☐ Walking
☐ Manicures in the Day Center
☐ Any other area of special interest: _____
_____
_____
_____

Member Initials: _____

CarePartners Standard Media Release

As a recipient of CarePartners Dementia Day Center services, I_____, understand that photographs will be taken at various times for various reasons. I agree to have the member's photos and videos taken for the following reasons (write in "Yes" or "No" as applies):

___ Identification

___ Activities posted within the Center

___ Publicity for the Center (brochure, ads, flyers)

___ For media publication (videos, news, reports, newspaper stories)

By writing "yes" to Publicity or Media Publications, I agree to and understand the following:

- I agree to grant to CarePartners (hereinafter Agency), its advertising agency, licensees, and producers of its educational and promotional materials and their successors and assigns, the right to use, publish, and copyright the Day Center picture, voice, and/or moving image for educational programs, advertising, and promotion of Agency programs as described above.

- I understand that this right includes the right to combine picture, voice, and/or moving image with others and the right to alter any of these for the purposes described above. I also understand that once the picture, voice, or moving image is placed on an Agency web site or other form of media, including electronic, it may be viewed or used on or off campus.

- I agree to release the Agency and all its officers, employees, and agents from any liability claims and costs of whatever kind that occur in connection with my actions while being photographed or recorded for the Agency.

I understand that I have the right to refuse consent for photographs based on my right to privacy.

Upon occasion, CarePartners may feature stories about our members either through our Day Center monthly newsletter or through our agency website and blog. Please agree or disagree to the following statement (circle agree or disagree):

I agree / disagree to share the member's first name in featured stories.

_____ _____

Signature of Caregiver/Responsible Party **Date**

Member Initials: ___ _

Field Trip Agreement

The CarePartners Dementia Day Center likes to enrich our program by scheduling neighborhood outings, or field trips, for appropriate participants. Examples of such outings include excursions to museums, the arboretum, special attractions, window-shopping, or picnics in the park. The participants taken for each field trip will be chosen according to their abilities and interests. These field trips from the Day Center will be posted on the monthly calendars as "Van Adventures".

The group size for each field trip will usually be up to 9 participants and at least 2 staff members. When we can charter a larger vehicle, some field trips may allow more participants to attend. Some participants may need to be excluded from field trips due to their inability to leave the Day Center's secure and familiar environment. **Field trips are usually scheduled between 9:00 a.m. and 3:00 p.m. and families have the option to be notifiedbefore the field trip occurs**.

In signing this agreement, you are releasing CarePartners and CarePartners Dementia Day Center from any liability for any injuries incurred during our field trips. The Day Center staff will carefully supervise all members and will do everything possible to protect their health and safety.

Please initial the statement that best describes your interest in allowing your loved one to participate: (Chose one)

___ I agree to allow_____ to participate in the described field trips and do not need to be notified in advance of his or her participation and understand that I should notify the Day Center if I am to pick him or her up earlier than scheduled.
Member

___ I agree to allow_____ to participate in the described field trips but request that I be notified in advance of his or her participation on each field trip.
Member

___ I do not consent to_____'s participation in Day Center field trips.
Member

I will notify the Day Center, in writing prior to the field trip, if-after giving my permission- the member will not be allowed to participate in a field trip.

_____ _____

Signature of Caregiver/Responsible Party **Date**

Medical History

Member's Full Name: _____

Member's Memory Information

Initial Symptoms of Dementia Began: __/__/__ Date of Diagnosis __/__/__

Describe onset and course of memory impairment:

_____

Family History of Dementia?____Yes_____No

Does he/she move back and forth between past and present? (Confusing current circumstances with past events)
Yes No

Member's Personality Information

Has his/her personality altered since dementia onset? _____Yes _____No

Comments:

_____

_____

How does he/she cope with stress?

____Verbal outburst ____Withdraw _____Increased movement

____Anxiety or worry_____Other: _____

Does he/she exhibit catastrophic reactions (*definition: sudden change of mood to anger or violence, often with misdirected behavior, combativeness, crying, pacing, restlessness, repetitive hand motions like clapping or stomping feet or increased strength.)*_____Yes _____No

Please describe:

_____

_____

What triggers changes in behavior? (*i.e., places with a lot of noise, gets angry when someone tries to help in the bathroom)*

Please explain:

_____

_____

Does he/she engage in inappropriate sexual behavior?_____Yes _____No

Please explain:

_____

_____

Member's Knowledge of the Disease

Please choose the best description of his/her knowledge of his/ her diagnosis.

_____Knows of/Is aware of ____Refers to impersonally _____Does not know

_____Past awareness of ____Unknown

Hospitalizations and Illness Information

Most Recent Hospital admission_____

Reason for admission:_____

_____

_____

Please tell us about any emotional or physical traumas, major surgeries, and illnesses.

_____

_____

_____

Special Notes

Member Initials: _____

Physician and Insurance Information

Physician Information
Primary Care Physician:
Phone: | Specialty:
Address:
City, State, Zip:
Affiliated Hospital:

Additional Physician:
Phone: | Specialty:
Address:
City, State, Zip:
Affiliated Hospital:
Insurance Information (For emergencies only)
Medicare Number: Part A___Part B_____Both_____
Medicare HMO ____Yes No
Insurance Company Name: _____
Individual ID Number: _____
Group number: _____
Telephone Number: _____
Secondary Insurance Company Name: _____
Individual ID Number: _____
Group number: _____
Secondary Insurance Telephone Number: _____

Member Initials: _____

In the event of an emergency, which hospital would you like your loved one transferred to?

_____

Member Initials: _____

Advance Directives

The CarePartners Dementia Day Center is required by law to provide you with written information about Advance Directives and any related Day Center policies. Your signature below indicates acknowledgement and/or verification of the following:

- I have received a copy of the Advance Directives policy of the CarePartners Dementia Day Centerincluded in the Family Policies and Procedures Handbook.
- I have been informed about my rights to formulate Advance Directives.
- I have been given written information about a Directive to Physician (Living Will) and a Medical Power of Attorney.
- I understand that neither my loved one nor I is required to have an Advance Directive to enroll orparticipate at the Day Center.

The following provides current information regarding Advance Directives formulated for/by the individual (member) attending the Day Center.

The following Advance Directives have been executed:

_____ Directive to Physician (Living Will) *Responsible Party:* _____

_____ Medical Power of Attorney *Responsible Party:* _____

_____ Other: Please specify _____

_____ None

A copy of the following Advance Directives have been provided to the Day Center:

_____ Directive to Physician (Living Will)

_____ Medical Power of Attorney

_____ Other: Please specify _____

_____ None

_____ _____

Signature of Caregiver/Responsible Party **Date**

Member Initials: _____

Acknowledgement of Receipt
Family Policies and Procedures Handbook

The Family Policies and Procedures Handbook contains important information about CarePartners Dementia Day Center. It is the responsibility of the caregiver or responsible party to review the Handbook before enrolling in the Day Center and comply with all policies.

The information, policies, and procedures described are subject to change at any time, and revisions will be communicated through official notices.

My signature below indicates I have received a copy of the Family Policies and Procedures Handbook and I understand and will adhere to the policies of CarePartners Dementia Day Center.

_____ _____

Signature of Caregiver/Responsible Party **Date**

Member Initials:_____

Acknowledgement of Receipt
Human Resource Code: Rights of the Elderly

It is required that CarePartners provide a copy of the Human Resource Code: Rights of the Elderly to each of our clients included in the Family Policies and Procedures Handbook. You are required to do nothing but receive this copy, but we do recommend that you read and keep it.

My signature below indicates that I have received a copy of the Human Resource Code: Rights of the Elder and understand the rights of the member.

_____ _____

Signature of Caregiver/Responsible Party **Date**

· Member Initials:_____

Acknowledgement of Receipt
Notice of Privacy Practices

Dear CarePartners Family,

It is required that CarePartners provide a copy of the Notice of Privacy Practices to each of our clients. This copy is yours to keep and is located in the **Day Center Family Policy and Procedures Handbook.** You are required to do nothing but receive this copy, but we do recommend that you read and keep it.

Please print and sign your name below. Your signature acknowledges only that you have received a copy of your Privacy Rights.

Thank you so much for your cooperation. Your support enables us to continue to provide the highest quality service to all our clients. If you have any questions regarding privacy issues, please call our Privacy Officer at 713-682-5995.

I acknowledge that I have received a copy of CarePartners's Notice of Privacy Practices.

_____ _____
Signature of Caregiver/Responsible Party **Date**

_____
Printed Name of Caregiver/Responsible Party

_____
Printed Name of Member

Member Initials: _____

Consent for Day Center Services

I have reviewed and understand the policies and procedures of the Day Center included in the Family Policies and Procedures Handbook and agree to abide by the terms therein.

I will not hold any of the staff, volunteers, directors, and officers of CarePartners and/or CarePartners Senior Services responsible for any injury to the above named member during the course of the Day Center program.

I give my permission for _____ to participate at the CarePartners Dementia Day Center.
(Member's Name)

_____ _____

Signature of Caregiver/Responsible Party **Date**