

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!

Tyra Hunter
Director

Vanessa Pierce, RN Nurse



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 typically limited to Mondays, Wednesdays, and Fridays at 10am and 3pm. Appointments are made on a first come, first served basis and contingent on the availability of the Day Center staff.



Enrollment Forms

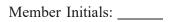
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Member Initials: _

Day Center Admission Form



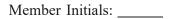
Name:				_	
Address:					
City, State, Zip:					
Home Phone:					
Demographic Information					
Birth Date:	Age: Gend	ler:	Veteran (circle one): Y	es No	
Racial/Ethnic Background:		Marital St	atus:	_	
Member's Monthly Income:		(Collected t	for statistical purposes only.,)	
Monthly <u>Household</u> Income:		(Collecte	ed for statistical purposes on	nly.)	
Current Home Environment:					
Lives with:					
How does the individual feel a	about attending the	Day Cente	r?		
	_ Accepting _ Complacent _ Angry _ Doesn't Comprehend _ Depressed _ Unaware _ Bitter _ Other:				
Planned Mode of Transportat	tion to/from center:				
Private AutoTrai	nsportation Provide	r (list provider)	:		
Primary Contact Information	on				
Name:	_	Relationshi	p to Member:		
Mailing Address:					
City, State, Zip:					
Home Phone: Cell Phone:					
Email Address:					
Is the billing contact different from the Primary Contact?YesNo					
If Yes, please provide his or her contact information below:					
NameRelationship to Member:					
Mailing Address:	Mailing Address:				
Email Address:	Email Address:				
Phone Number:					





Biographical Information

Family	
Where was childhood spent:	
Number and names of siblings:	
Number still living:	
Spouse's Name (if applicable):	Is spouse living:YesNo
Number and names of children:	
Number still living:	
Number of grandchildren:	Number of great grandchildren:
	n school, graduate school, no formal schooling) :
	st Guard, Air Force, Navy):
Former Occupation(s):	.Last Employer:
Comments:	
Religious Preference: (i.e. Christian, Jewa Comments:	ish, Atheist, Buddhist):
Primary Language(s):	

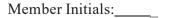




Additional Background Information

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.

Describe your loved one's typical day. Include favorite activities and regularly scheduled appointment
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.
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.
Please describe your loved one's preferred social setting. (i.e. small group, one-on-one, large group; please no anyone he or she may feel uncomfortable with)





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:
HomePhone:		WorkPhone	e:	Cell:_	
Employer:		M	Iilitary Status:	: _Veteran _Ac	tive Duty _NIA
May contact regard	ding billi	ng? _Yes _ No	May contact	t regarding care	e? _ Yes _ No
DOB:	Sex:	Race:		Marital Statu	s:
Monthly Income:					
Sacandam, Canadina	on Contact				
Secondary Caregive			Delationshir	··	
Address:					
Employer:		M	lilitary Status:	_Veteran _A	ctive Duty _ <i>NIA</i>
May contact regard	ding billin	ng? _ Yes _ No	May contact	t regarding care	e? _ Yes _ No
DOB:	Sex:		Marital	Status	
Monthly Income:		Lives with Men	mber?	Yes_	
			No		
Third Caregiver Co	ntact:				
Name:			Relationship	p:	
Address:			City:		Zip:
HomePhone:		Work Phone):	Cell:_	
Employer:		M	ilitary Status:_	Veteran	Active Duty _N/A
May contact regard	ding billir	ng? _ Yes _ No	May contact	t regarding care	e? _ Yes _ No
					s:
Monthly Income:		Lives with Me	mher? Yes	No	



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.			
the ab		ntia Day Center to allow my family memberis/her listed caregiver(s). They will be a	
	Signature of Caregiver/Responsib	le Party Date	te

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Member Initials:	
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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.

	ies from 1 to 5. If he or she is not interes once in a while 5=Always enjoys	· · · · · · · · · · · · · · · · · · ·
EXAM	PLE:5_ Church Services (always 1_ Dancing (will dance upor Card Games (never plays	n occasion)
Art appreciation	Collection (coins, stamps, etc.)	Play a Musical Instrument
Art work (drawing or painting)	Singing	
Arts and Crafts	Dancing	Reading
Bible/devotional reading Church Services	Listening to Music Favorites:	Magazines Books Poetry
Conversation or discussion with peers	Outings	Newspaper Writing
Cooking	Community events Antique shops	Sports
Sewing	Museums Nature trails Other	Favorites:
_ Domestic Chores (sweeping,	Trivia Games	Fishing
folding clothes, etc.)	Word Games (word search,	Walking
Crocheting	crossword puzzles, etc.)	<u> </u>
Knitting/Needlework	Table games	Manicures in the Day
Electronics	Puzzles	Center
Movies		Any other area of special
Favorites:	Casino Games	interest:
	Dominoes	
Exercise or fitness routines	Bingo	
Gardening (including house	Card Games	
plants)	Describe:	
Woodworking	Pets:	
Home decorating	Picnics	
Travel	Volunteering	



Member Initials:	
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CarePartners Standard Media Release

	I agree / disagree to share the mem	ber's first name in featured stories.
	casion, CarePartners may feature stories about our mer or through our agency website and blog. Please agedisagree):	· ·
I understa	and that I have the right to refuse consent for photog	raphs based on my right to privacy.
co	agree to release the Agency and all its officers, emplosts of whatever kind that occur in connection with a por the Agency.	
an pio	understand that this right includes the right to combine and the right to alter any of these for the purposes desicture, voice, or moving image is placed on an Agen lectronic, it may be viewed or used on or off campu	scribed above. I also understand that once the cy web site or other form of media, including
its co	agree to grant to CarePartners (hereinafter Agency), as educational and promotional materials and their surperight the Day Center picture, voice, and/or moved promotion of Agency programs as described about	ccessors and assigns, the right to use, publish, and ing image for educational programs, advertising,
By writing	ng "yes" to Publicity or Media Publications, I agree to	o and understand the following:
For	r media publication (videos, news, reports, newspap	erstories)
Pub	blicity for the Center (brochure, ads, flyers)	
Act	etivities posted within the Center	
Ideı	entification	
understand	cipient of CarePartners Dementia Day Center s and that photographs will be taken at various times for and videos taken for the following reasons (write in "Y	r various reasons. I agree to have the member's



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 notified before 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	s 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	r her participation and understand that I should notify the
Day Center if I am to pick him or her u	up earlier than scheduled.
_	to participate in the described field trips but request
that I be notified in advance of his or h	er participation on each field trip.
I do not consent to Memb	_'s participation in Day Center field trips.
I will notify the Day Center, in writing prior member will not be allowed to participate in	to the field trip, if-after giving my permission- the 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:



Carepartite
Member's Knowledge of the Disease
Member's Knowledge of the Disease
Please choose the best description of his/her knowledge of his/ her diagnosis.
Knows of/Is aware ofRefers to impersonallyDoes not know
Past awareness ofUnknown
Hospitalizations and Illness Information
Most Recent Hospital admission
Reason for admission:
Please tell us about any emotional or physical traumas, major surgeries, and illnesses.
Trease ten us about any emotional of physical traumas, major surgeries, and finiesses.
Special Notes
Special Notes



Member In	itials:

Physician and Insurance Information

Physician Information		
Primary Care Physician:	:	
Phone:	I 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 APart BBoth
Medicare HMO	Yes	No
Insurance Company Na	ame:	
Individual ID Number:		
Group number:		
Telephone Number:		
Secondary Insurance Co	ompany Name:	
Individual ID Number:		
Group number:		
Group number.		
Secondary Insurance T	elephone Number:	

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

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Member Initials:	
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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:	<u> </u>
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	





Acknowledgement of Receipt Family Policies and Procedures Handbook

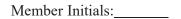
The Family Policies and Procedures Handbook contains important information about CarePartners Dementia Day Center. It is the responsibility of the caregiver or responsible party to review the Handbook before enrolling in the Day Center and comply with all policies.

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	

CarePartners Dementia Day Center Enrollment Forms Revised January 2022

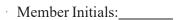




Acknowledgement of Receipt Human Resource Code: Rights of the Elderly

It is required that CarePartners provide a copy of the Hu Elderly to each of our clients included in the Family Pol- required to do nothing but receive this copy, but we do	icies and Procedures Handbook. You are
My signature below indicates that I have received Rights of the Elder and understand	• •
Signature of Caregiver/Responsible Party	

CarePartners Dementia Day Center Enrollment Forms Revised January 2022





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.

Signature of Caregiver/Responsible Party	Date		
Printed Name of Caregiver/Responsible Party	_		
Printed Name of Member	_		

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

CarePartners Dementia Day Center Enrollment Forms Revised January 2022



Member Initials:		Member	Initials:	
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