



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.

In this packet, you will find a Provider's Orders form. This form must be completed by a medical provider and should state a diagnosis of dementia or a related disease that causes memory impairment. All members are required to have a completed Tuberculosis (TB) skin test within the last year.

If you have any questions or concerns, please don't hesitate to contact us. Again, Welcome to CarePartners' Dementia Day Center!

Tyra Hunter
Activity Director

Angie Meus
Registered Nurse

Alandria Franklin, MSW
Director



CarePartners

Enrollment Check List

Thank you for considering CarePartners' Dementia Day Center. We look forward to having you and your family join 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) skin test or provide record of results if tests were performed within the last year.
- 3) ____ Submit Provider'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 completed.* 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 Provider'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 2 pm. Appointments are made on a first come, first serve basis and are contingent on the availability of the Day Center staff.

Member Initials: _____



Enrollment Forms

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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: _____ <i>(Collected for statistical purposes only.)</i>			
Monthly Household Income: _____ <i>(Collected for statistical purposes only.)</i>			
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:			
<input type="checkbox"/> Private Auto <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please provide his or her contact information below:</i>
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, graduates 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 will benefit from day center services, including family caregivers receiving respite. Please complete this information as accurately as possible along with *the information requested in italics is for statistical purposes only. It 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

 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

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

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

 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, including the caregiver other than his/her listed caregiver(s). They will be asked to provide a valid form of identification upon arrival.

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. 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 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
Member
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.

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

___ 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 (<i>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.</i>) ___Yes ___No
Please describe: _____ _____
What triggers changes in behavior? (<i>i.e., places with a lot of noise, gets angry when someone tries to help in the bathroom</i>) Please explain: _____ _____
Does he/she engage in inappropriate sexual behavior? ___Yes ___No Please explain: _____ _____

Member's Knowledge of the Disease
<p>Please choose the best description of his/her knowledge of his/ her diagnosis.</p> <p> <input type="checkbox"/> Knows of/Is aware of <input type="checkbox"/> Refers to impersonally <input type="checkbox"/> Does not know <input type="checkbox"/> Past awareness of <input type="checkbox"/> Unknown </p>

Hospitalizations and Illness Information
<p>Most recent hospital admission _____</p> <p>Reason for admission: _____</p> <p>_____</p> <p>_____</p> <p>Please tell us about any emotional or physical traumas, major surgeries, and illnesses.</p> <p>_____</p> <p>_____</p> <p>_____</p>

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

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 Center included 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 my loved one and I are not required to have an Advance Directive to enroll or participate 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. This is included in the Family Policies and Procedures Handbook. Please read and retain for your records.

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**. Please read and retain for your records.

By printing and signing your name below, your signature acknowledges 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 of 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' 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. I agree to abide by the terms therein.

I will not hold any of the staff, volunteers, directors, and officers of CarePartners and/or CarePartners' Programs and Services responsible for any injury to the below 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