

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



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 <u>DayCenter@CarePartnersTexas.org to</u> 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.



Enrollment Forms

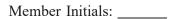
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Member Initials:_

Day Center Admission Form



Name:				
Address:				
City, State, Zip:				
Home Phone:				
Demographic Information				
Birth Date:	Age: Ge	ender:	Veteran (circle one): Yes	No
Racial/Ethnic Background:				
Member's Monthly Income:			ed for statistical purposes only.)	
Monthly <u>Household</u> Income: -			ected for statistical purposes only.)	
Current Home Environment:				
Lives with:				
How does the individual feel	about attending t	he Day Cen	iter?	
_ Accepting _ 0 _ Depressed _	Complacent _ Unaware _	Angry Bitter	_ Doesn't Comprehend _ Other:	_
Planned Mode of Transportat				
Private AutoTrai	nsportation Provid	der (list provid	ler):	
Primary Contact Information	on			
Name:		Relation	ship to Member:	
Mailing Address:				
City, State, Zip:				
Home Phone:				
Email Address:				
Is the billing contact differer	nt from the Primary	/ Contact?_	YesNo	
If Yes, please provide his or her co	ntact information belo	w:		
Name	Re	lationship t	o Member:	
Mailing 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:
Comments:	
	ool, graduateschool, noformalschooling):
	ard, Air Force, Navy):
Former Occupation(s):	LastEmployer:
	Atheist, Buddhist):
Primary Language(s):	

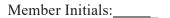
Member Initials	s:



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.

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			
2				
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)			





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 Cor	ıtact:		
Name:	Relationship:		
Address:		City:Z	ip:
HomePhone:	Work Phone:	Cell:	
Employer:	Military	Status: Veteran_ Active Du	ty_
May contact regardin	ng billing?_Yes_ No May	contact regarding care?_ Ye	s_ No
DOB: S	Sex: Race:	Marital Sta <u>tus:</u>	
	Lives with Member?		
Secondary Caregiver C	'antact•		
	Relationshi	in:	
	City:		
	Work Phone:		
	Military		
	g billing? _ Yes _ No May c		
	Race		
	Lives with Member? Yes		
	Lives with Member?, 1 es	INO	
Third Caregiver Contac	rt:		
<u> </u>	Relat	ionship:	
	Work Phone:		
	Military S		
	billing? _ Yes _ No May c		
	Sex: Race:		
	Lives with Member?		





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. 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.			
with tl	-	ntia Day Center to allow my family mo ling the caregiver other than his/her ntification upon arrival.	
	Signature of Caregiver/Responsible	e Party D	ate

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

=	ties from 1 to 5. If he or she is not inter once in a while 5=Always enjo	rested at all, you may leave it blank.
	MPLE: _5_ Church Services (alwa _1_ Dancing (will dance Card Games (never pla	nys wants to participate) upon occasion)
Art appreciationArt work (drawing or painting) Arts and Crafts	Collection (coins, stamps, etc.)SingingDancing	Play a Musical Instrument Describe: Reading
Bible/devotional reading Church Services	Listening to Music Favorites:	Magazines Books Poetry
Conversation or discussion with peers _CookingSewingDomestic Chores (sweeping, folding clothes, etc.)CrochetingKnitting/Needlework Electronics Movies Favorites:	Community eventsCommunity eventsAntique shops Museums Nature trails Other Trivia Games Word Games (word search, crossword puzzles, etc.)Table games Puzzles Casino Games Dominoes	NewspaperWritingSportsFavorites:
Exercise or fitness routines Gardening (including house plants) Woodworking Home decorating Travel	_Bingo Card Games Describe: Pets: Picnics Volunteering	



Member Initials:	
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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





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 describe	es 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.
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.
	's participation in Day Center field trips.
I will notify the Day Center in writing prior t 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	y 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 ofRefers to impersonallyDoes not know
Past awareness ofUnknown
Hospitalizations and Illness Information Most recent hospital admission
Most recent hospital admission
Reason for admission:
Please tell us about any emotional or physical traumas, major surgeries, and illnesses.
Special Notes



Member Initials:	
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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 APart B	_Both
Medicare HMO	Yes No		
Insurance Company Na	me:		
Individual ID Number:			
Group number:			
Telephone Number:			
Secondary Insurance Co	ompany Name:		
Individual ID 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?	

Member muais:	Member	Initials:	
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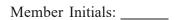
Advance Directives

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	





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.

	<u></u>	
Signature of Caregiver/Responsible Party	Date	

CarePartners' Dementia Day Center Enrollment Forms Revised February 2025

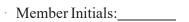




Acknowledgement of Receipt Human Resource Code: Rights of the Elderly

It is required that CarePartners provide a copy of the I	Human Resource Code: Rights of the
Elderly to each of our clients. This is included in the I Please read and retain for your records.	e
My signature below indicates that I have received	
Rights of the Elder and understand the rights	of the member.
Signature of Caregiver/Responsible Party	Date

CarePartners' Dementia Day Center Enrollment Forms Revised February 2025





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.

Signature of Caregiver/Responsible Party

Printed Name of Caregiver/Responsible Party

Printed Name of Member

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

CarePartners' Dementia Day Center Enrollment Forms Revised February 2025





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