ADULT DAY SERVICES

Name: Date of Birth:
Address:

FACE SHEET

Start Date _____ Schedule _____
Private VA PHS Sliding Scale TB chg.

Billing Name _____

Billing Address _____

Phone: HOME _____ CELL _____

E-Mail Address_____

SSN: _____

EMERGENCY CONTACT: _____ Phone: _____

2nd Contact: _____Phone: _____

Referred by: _____

Diagnosis: _____

Med and/or Food Allergies: _____

Special Diet Instructions: _____

Marital Status: _____ Race: _____ Primary Language: _____

Primary Care Physician:
Name: _____ Phone: _____

Power of Attorney: Y ___ N ___ Lifesaving Instructions: *DNR* *FULL CODE*
Media Release: Y ___ N ___
Education/Work Bkgrd. _____

Original: Participant's file Copies: 1) Accounting
2) Emergency Book
3) ADS director
4) Activities director

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ENROLLMENT AGREEMENT

CAREGIVER'S NAME: _____

CAREGIVERS'S ADDRESS: _____

_____

PHONE: _____

EMERGENCY CONTACTS: In the event of an emergency, the following person(s) should be contacted in the order listed:

	NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

HOSPITAL PREFERENCE: _____

ADULT DAY SERVICES

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ENROLLMENT AGREEMENT

I. ENROLLMENT REQUIREMENTS:

Casa Community Services by Posada Life's Adult Day Services program is available to any adult 55 years and older who is in need of supportive day services due to a physical, mental, or emotional impairment. Some exceptions are made for younger adults, and are determined on an individual basis. Only in instances when the participant has a communicable disease, is at risk of harming self or others, or is deemed total care, will enrollment be denied.

The following descriptions detail the enrollment procedures and services to be offered:

Enrollment to the Program:

- Following the initial call, the participant will be assessed at the center or in the home by a social service provider.
- During the visit, information will be obtained regarding reasons for referral, care needs, and interests of the participant.
- Prior to enrollment, all necessary forms must be completed, reviewed, and signed by the participant/guardian/legal representative
- All participants must have a medical assessment completed by his/her medical provider and show freedom from pulmonary tuberculosis prior to enrollment. Your medical provider or the agency nurse at Casa can administer T.B. skin tests. If you have been tested within the last 6 months, a statement verifying the results is required.
- When all enrollment information is completed, Casa Community Services staff will arrange with the participant or representative a schedule of attendance. Transportation needs will also be established at this time.

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II. CUSTOMARY SERVICES:

Program Services:

All participants will be offered the following services.
While participation is voluntary, it is encouraged.

1. Supervision of the participants except for the periods of the day the participant signs out or is signed out according to facility's policies and procedures.

2. Assistance with activities of daily living and supervision of personal hygiene in accordance with the participant's care plan.

3. Planned therapeutic individual and group activities that address the physical, mental, emotional, social, and spiritual needs of the participant in accordance with his/her care plan.

4. General health and social service assessments.

5. A licensed nurse shall monitor each participant's health status and medication in accordance with licensure requirements.

6. Nutritional services including snacks and a nutritionally balanced mid-day meal will be provided.

7. Transportation to and from the program, with a private service provider, is available for a fee.

8. Supportive counseling and referral for identified and necessary services.

9. Injuries from an accident or incident that affect the participant's health status are reported, investigated, and documented according to licensure requirements.

10. Support group at no charge for the family and/or caregivers.

Flexibility in hours of attendance is possible for those providing their own transportation.

All services are confidential and respect the rights of the participant and family.

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III. FEE SCHEDULE

A. FEE AND PROGRAM SCHEDULE

- Program Hours: Monday - Friday 9:00 AM – 4:00 PM
- RATE: Full Day = 7 hours $62.00 per Day*,

  Drop-in Service/Hourly Rate $18.00 per Hour*
- Meals:

  All participants are offered a morning snack at 9:15 AM, a hot lunch at Noon, and an afternoon snack at about 3:00 PM. Cost of lunch and snacks are included in the daily fee.
- Additional Fees:

  A one-time intake fee of $30 will be charged upon the start of services.

  A $30 annual insurance fee is applied for each participant. It will be billed upon the start of services and annually thereafter.

  Arizona Department of Health Services requires all participants to provide evidence of freedom from pulmonary tuberculosis prior to starting the program and annually thereafter. A PPD test is available through Casa Community Services for an additional $25 fee.

* ***Prices are subject to change***.

B. FEE AND ATTENDANCE POLICIES

BILLING: Fees are billed on a monthly basis.

UNSCHEDULED ATTENDANCE/ABSENCE POLICY: All visits to the Adult Day Center must be scheduled. A $10.00 surcharge will be assessed for unscheduled visits. If notification of absence is not received prior to 5:00 p.m. the preceding day, a $10.00 surcharge will be added to the statement.

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LATE CHARGES (After 4:00 p.m.):

- 5-15 minutes – additional charge….$7.50
- 16-30 minutes – additional charge….$15.00

ABILITY TO PAY: Eligibility into the Adult Day Services Program is solely based on need and not on ability to pay. If a participant is unable to pay the fee, the applicant will complete a sliding fee scale form and Casa Community Services will review the possibility of subsidizing the cost of the program through Pima Health Systems, scholarships or other alternative funding sources.

IV. TERMINATION OF THE ENROLLMENT AGREEMENT

The Enrollment Agreement can be terminated by the participant or their representative at any time by submitting a written request.

The administrator may terminate an Enrollment Agreement after giving the participant or participant's representative a five day written notice for any of the following reasons:

1. Evidence of repeated failure to abide by the facility's rules, which includes chronic absenteeism,

2. Documented proof of failure to pay,

3. Behavior which is dangerous to self or which interferes with the physical or psychological well-being of other participants or

4. Participant's service requirements exceed those services that the facility is licensed and able to provide.

The administrator shall ensure that a discharge plan is included in the care plan and shall include recommendations for continuing care and referrals to community service agencies.

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V. PARTICIPANT RIGHTS:

A participant shall have the following rights:

A. To be treated with consideration, respect and full recognition of the dignity and individuality of each participant;

B. To be free from the following:
1. Medical, psychological, physical and chemical abuse;
2. Physical restraints; and
3. Use of psychoactive drugs administered for the purpose of discipline, or convenience and not required to treat the participant's medical symptoms;

C. To refuse treatment or withdraw consent for treatment;

D. To participate in the development of and receive the services specified in the care plan;

E. To have medical and financial records kept in confidence. The release of Records shall be by written consent of the participant or participant's representative, except as otherwise required or permitted by law;

F. To inspect the participant's own records at a time agreed upon by the participant and the facility.

G. To be informed of the following:
1. Rates and charges for the use of the facilities and,
2. The process for contacting the local Adult Protective Services office;

H. To communicate, associate and meet privately with persons of the participant's choice;

I. To have access to a telephone, to make and receive calls, to send and receive calls, and to send and receive correspondence without interception or interference by the facility;

J. To arrive and depart from the facility freely, consistent with the participant's care plan and personal safety; and

K. To exercise other civil rights and religious liberties, including the right to make personal decisions and to submit grievances without retaliation.

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VI. FACILITY RULES:

A. Enrollment in the Adult Day Services Program will include the following Services, responsibilities and policies:

1. Selection of regular days of attendance is preferred, and only in certain circumstances may a participant attend on an unscheduled basis.

2. Comprehensive health and social service assessment will be offered on an ongoing basis. All initial assessments will be completed within 30 calendar days of enrollment or by the 10th visit.

3. An Individual Care Plan will be developed within seven days after the completion of the comprehensive assessment. The participant and/or the participant's representative and service providers are welcome to attend any care plan meeting and assist in the development of the Care Plan with the ADS staff. The Care Plan will be reviewed and updated every six months or earlier when there is a significant change in the participant's condition. Copies of the plan can be obtained by the participant or the participant's representative.

4. Additional therapies and services are available upon referral. Consultation with the participant and family will precede all referrals. ADS is not responsible for any costs incurred through referral to other services.

5. Each participant must provide a signed, written Medical Assessment completed by the participant's medical provider and show freedom from communicable diseases.

6. For the safety of all, smoking is not permitted while at the ADS or on La Posada campus.

7. Any food item brought to the center must comply with state dietary regulations.

8. ADS is not responsible for lost personal items.

9. Participants are enrolled for a 30 day assessment period (one month from admission date). During the assessment, both staff and participant/family will determine the appropriateness of the service. If determined that alternative care is needed, ADS will assist in the referral process.

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VII. ADVANCED DIRECTIVES:

All participants and/or their caregivers are required to complete and sign a directive pertaining to resuscitation procedures in the event of a medical emergency at the ADS. If the participant and/or the participant's legal representative elects the "Do Not Resuscitate" clause, it is required that a copy of the participant's Living Will and/or Health Care Power of Attorney and a Pre-Hospital Medical Care Directive (ON ORANGE PAPER ONLY) be submitted to Casa Community Services by Posada Life to be kept in the participant's clinical chart.

If the participant or the legal representative of the participant should elect to change the designation of the resuscitation directive prior to the expiration of the Resuscitate form, it shall be the responsibility of the participant, or the participant's legal representative, to inform Casa Community Services by Posada Life of the change, whereupon the appropriate paperwork will be completed.

VIII. CONFIDENTIALITY STATEMENT

Casa Community Services by Posada Life's ADS is dedicated to assuring that all services provided to participants remain confidential. All documentation with participant identifying information must remain at the agency or under the supervision of authorized staff. Confidentiality can only be breached in life threatening situations, or when the participant has signed a release to a specified source. All signed releases will be valid for one year following the dated signature.

IX. GRIEVANCE PROCEDURE

Every participant served by Casa Community Services by Posada Life has the right to express their grievances regarding services. A grievance may be expressed to any Center employee. Upon notice of a grievance, the report shall be given to the Program Director. The Director will investigate the grievance and report findings to the participant. Appropriate actions will be taken as needed. Reports can also be made directly to the Program Director by a participant. The agency Director will be notified of all grievances, the nature of the grievance, and disposition of same.

X. NON DISCRIMINATION POLICY

The service of Casa Community Services by Posada Life are available to all residents meeting the needs criteria of the greater Green Valley, AZ area regardless of age, gender, race, religion, or ability to pay.

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SIGNATURE PAGE

I, _____, will be responsible to pay all charges incurred as a result of _____being enrolled in Adult Day Services at Casa Community Services by Posada Life.

With my signature below, I hereby acknowledge that I have received a copy of, read and understand all clauses contained in this Enrollment Agreement.

PARTICIPANT OR PARTICIPANT'S LEGAL REPRESENTATIVE

NAME _____

SIGNATURE _____DATE_____

CASA COMMUNITY SERVICES by POSADA LIFE

NAME _____Title _____

SIGNATURE _____DATE_____

ADULT DAY SERVICES

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Dear Medical Provider:
It is a requirement of the Arizona Department of Health Services that each participant enrolled in the Adult Day Services at Casa Community Services by Posada Life submit a signed, written medical assessment completed by the participant's medical provider prior to enrollment. The assessment must not be completed earlier than 60 days prior to the date of enrollment and must be signed by one of the following: 1) Physician, 2) Physician's Assistant or 3) Nurse Practitioner. Please complete and return this form to the participant, his/her caregiver or to our office. (Fax #: (520) 625-1598) Thank you for your cooperation.

MEDICAL ASSESSMENT

PLEASE NOTE THE FOLLOWING (Attach additional sheets if necessary):

ALLERGIES & Treatment (Please include Drug, Food, Environmental, etc.):

_____

_____

PRIMARY DIAGNOSIS(ES): _____

_____

SECONDARY DIAGNOSIS(ES): _____

_____

CURRENT MEDICATION SCHEDULE (Please include doses, how often etc.):

_____

_____

_____

_____

_____

_____

_____

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What can we give the participant if he/she has minor pain?

Tylenol 650 mg. PO Q 6 HOURS PRN ☐

Ibuprofen 400 mg. PO WITH FOOD Q 6 HOURS PRN ☐

GENERAL HEALTH: _____
_____

COGNITIVE AWARENESS OF SELF, LOCATION AND TIME/IMPAIRMENT: ___
_____
_____

PHYSICAL IMPAIRMENTS: _____
_____
_____

BEHAVIORAL/EMOTIONAL HEALTH: _____
_____
_____

COMMUNICABLE DISEASES: _____
_____

TUBERCULOSIS CLEARANCE - Date of last PPD & Results: _____

If positive PPD, provide date & results of chest X-ray: _____

SPECIAL DIETARY REQUIREMENTS: _____
_____

LIST OF CURRENT TREATMENTS: _____
_____

ADULT DAY SERVICES

Name: Date of Birth:
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MEDICAL PROVIDER: _____

NAME: (Please print): _____

TITLE: _____

TELEPHONE #: _____ FAX #:_____

SIGNATURE: _____ DATE; _____

ADULT DAY SERVICES

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EMERGENCY MEDICAL CARE: In the event that emergency medical care becomes necessary, I give permission for the ADS staff to provide treatment as determined necessary. This may include calling 911. I understand that I am responsible for any costs incurred for emergency medical care.

MEDICATION AUTHORIZATION: If I need medications administered, I authorize Adult Day Services staff to administer medications that are prescribed, in writing, by participant's physician. I understand that if medications are administered, I will bring them in the original container and that no self-packaged medications will be accepted. If any changes occur in dosage of prescriptions, I will notify ADS staff and confirm that new medical provider orders are on file.

MEDIA RELEASE: On occasion, Casa Community Services may use pictures of ADS participants in our newsletter, annual report, GV newspaper, social media or website.

1. YES_____ Participant's picture may be used as circled above.
2. NO_____ Participant's picture may not be used for above.

SIGN IN/OUT DETERMINATION: In consultation with the Caregiver, it has been agreed that _____, participant, MAY/MAY NOT sign himself / herself in or out of the Adult Day Services program. WAIVER: Knowing full well that Adult Day Services staff are not responsible for individuals who have signed out, I hereby authorize Adult Day Services staff to sign _____ in or out for attendance purpose. This procedure has been reviewed with the Participant and/or Caregiver.

By signing below, I agree to the above rules and regulations:

_____ _____
Legal Representative Date

_____ _____
Witness Date

ADULT DAY SERVICES

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RESUSCITATION DIRECTIVE

As the participant or legal representative of the above mentioned participant, I understand and agree to the following:

1) The above mentioned participant will be considered to have a "Resuscitate Directive" in effect unless a completed Pre-Hospital Medical Care Directive, on orange paper, is fully executed and on file at ADS. _____ RESUSCITATE

2) The Pre-Hospital Medical Care Directive (DNR) must be fully completed, including Medical Provider's signature and witness signature on orange paper, per the Fire Department's emergency procedures and requirements. _____ DO NOT RESUSCITATE

If the participant or legal representative of the participant should change their choice about resuscitation, IT IS THE RESPONSIBILITY OF THE PARTICIPANT OR THE LEGAL REPRESENTATIVE OF THE PARTICIPANT TO INFORM CASA COMMUNITY SERVICES ADULT DAY SERVICES OF THE CHANGE, whereupon the new paperwork will be submitted to Adult Day Services.

_____ _____
Participant Date

_____ _____
Participant's Legal Representative Date

_____ _____
Witness Date

ADULT DAY SERVICES

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DISCHARGE PLANNING

An administrator for Casa Community Services Adult Day Services program or a participant and/or participant's representative may discharge a participant from the program by terminating the Enrollment Agreement. Casa Community Services Adult Day Services administrator must give the participant and/or participant's representative a five-day written notice.

The administrator shall ensure that a discharge plan for a participant is:

1. Developed that:
    a. identifies any specific needs of the participant after discharge,
    b. is completed before discharge occurs,
    c. includes a description of the level of care that may meet the participant's assessed and anticipated needs after discharge, and
    d. is documented in the participant's record within 48 hours after the discharge plan is completed; and
2. Provided to the participant or the participant's representative before the discharge occurs.

_____ _____

Legal Representative Date