Roitenberg Family Adult Day Center — Admission Agreement

The Roitenberg Family Adult Day Center hereby enters into this agreement with:

_____ and/or _____
Adult Day Center Member — Responsible Party

ROITENBERG FAMILY ADULT DAY CENTER AGREES TO:

1. Furnish supervision, administration of medications, assistance with activities of daily living, supervision of personal hygiene, health monitoring daily by the program nurse, supervised recreational and social activities, a therapy monitored exercise program, and meals and snacks provided by nutrition services as appropriate to the length of time spent at the Adult Day Center (ADC) each day.

2. Arrange for the transfer of the participant to the hospital, when ordered by the primary physician, and to notify the responsible party of said transfer.

ROITENBERG FAMILY ADULT DAY CENTER PARTICIPANT AND/OR RESPONSIBLE PARTY AGREES TO:

1. Pay the amount listed below for ***each day***. Meals and snacks are included in this amount.

   ☐ *Full Day $85.00* (6 hours) ☐ *Half Day $50.00* (3 hours or less) ☐ *Bathing (30 min.) $25.00*
   ☐ *Additional Hours $15.00/hour*

2. Allowance of one late cancel (canceling after 4:30 p.m. prior to client's scheduled day) per month. The late cancel rate is the agreed upon daily rate.

   Additional amount for transportation services. ☐ *Each trip $4.50* ☐ *Monthly Maintenance Fee $20*

3. After 4:30 closing, there is a $25 charge per half hour when members are late in leaving.

4. Provide clothing, undergarments, and continence products as needed or desired by the participant.

5. Provide spending money as needed or desired by the participant.

6. Provide medications prescribed by the participant's physician in a pharmacy labeled bottle.

7. Honor the smoke-free policy of the facility as addressed in the ADC handbook.

ROITENBERG FAMILY ADULT DAY CENTER PARTICIPANT AND/OR RESPONSIBLE PARTY AGREE THAT THE PROGRAM MAY:

1. Release information regarding the participant to the primary physician, county agencies, or other professional staff for professional use relating to quality care for the participant.

2. Allow the participant to leave the premises for outings and activities or treatment unless contraindicated by a physician's order or the request of a legally responsible party.

ROITENBERG FAMILY ADULT DAY CENTER HANDBOOK:

The ADC Handbook contains information about the program as mandated by the Minnesota Department of Human Services, as well as other helpful topics. Your signature on the Admission Agreement indicates that you have received this handbook, and that each section has been discussed with you.

FINANCIAL AGREEMENT:

1. The participant and responsible party agree to keep the account of the participant in good standing. Participants and the responsible party will be notified if a bill is in excess of 1 month past due, as this can be grounds to suspend participation in the ADC until such time as the account is made current.

2. The participant and responsible party authorize the ADC to contact emergency services as deemed necessary on behalf of the participant, and in doing so agree to pay for all expenses incurred on behalf of the participant in an emergency. The participant and/or responsible party agree to pay all hospital charges and other charges, separate from and in addition to, the daily charge of the ADC program.

3. Use of a physician, dental services, podiatry services, audiology services, the pharmacy, and any other similar parties will be billed to the participant and/or responsible party directly.

4. Service provided by the Sholom Therapy Department (i.e., registered physical therapist, registered occupational therapist, and speech therapist) are not included in the daily rate. Use of these services requires a physician's order, and will be billed to the participant and/or responsible party. Participants are free to use any vendor they choose.

VULNERABLE ADULTS ACT, PARTICIPANT'S BILL OF RIGHTS, and ORIENTATION CHECKLIST:

It is the responsibility of the ADC staff to know and practice the laws regarding the Vulnerable Adults Act and the Participant Bill of Rights. It is mandated that adults with a mental or physical disability, or those who use institutional services, be protected from abuse or neglect and that participants and others responsible for their care be made aware of the reporting procedure. Your signature on this Admission Agreement indicates that you have completed the orientation checklist, received a copy of the Participant Bill of Rights and a summary of the Vulnerable Adults Act, and that each has been reviewed with you.

It is the policy of the Roitenberg Family ADC to complete a Vulnerable Adult Assessment as part of the admission process. This assessment is reviewed and updated quarterly. Your signature on this Admission Agreement indicates that this assessment has been reviewed with you, and that you are aware of this policy.

PARTICIPANT SELF-PRESERVATION STATUS:

Participants who are able to take appropriate action in an emergency situation are 'self preservers.' The following is used to determine this status:

- ☐ The participant is ambulatory or mobile.
- ☐ The participant is able to recognize danger, signals, or alarms requiring evacuation from the ADC program.
- ☐ The participant is able to complete the evacuation without requiring more than sporadic assistance from another person.
- ☐ The participant is able to select an alternative means of escape or take other appropriate action if the primary escape route is blocked.
- ☐ The participant is able to remain at a designated location outside of the facility until further instruction is given.

Based on the criteria given, is this participant capable of self preservation? YES NO

Member/Responsible Party_____ Date _____
Signature

ADC Director_____ Date _____

Roitenberg Family Adult Day Center
Participant File

Admission Information

PERSONAL INFORMATION **Admission Date:**_____

Name _____ Date _____

Address _____

Home Phone _____ Other Phone _____

Date of Birth _____ Marital Status _____

Primary Language _____ Female Male

Current Living Situation _____

Primary Caregiver _____ Relationship _____

Phone Numbers _____

EMERGENCY and COMMUNITY CONTACT INFORMATION

Primary Emergency Contact – Is this contact a POA? Yes No

_____

NAME RELATIONSHIP PHONE(S)

_____

ADDRESS

Secondary Emergency Contact - Is this contact a POA? Yes No

_____

NAME RELATIONSHIP PHONE(S)

_____

ADDRESS

Physician _____

NAME PHONE

Clinic _____

_____

ADDRESS FAX

Hospital Preference _____

Transportation Service _____ Phone _____

Metro Mobility Certification Number if Applicable _____

Social Services Care Mgr._____ Phone _____

County Program if Applicable _____

BILLING and ATTENDANCE INFORMATION

Payment Source: _____ Private Pay _____ Waiver EW AC BI DD CADI _____ VA _____

Other: _____

Financially Responsible Person for Payment – Is this person financial POA? Yes No

_____

NAME RELATIONSHIP PHONE(S)

_____

ADDRESS

_____ Full Day – 6 hours

_____ Half Day – 3 hours

_____ Extra Hours

_____ Monday

_____ Tuesday

_____ Wednesday

_____ Thursday

_____ Friday

Personal Cares: _____Non-billable Shower/Bath _____Billable Shower/Bath

OTHER INFORMATION

How did you hear about the Roitenberg Family Adult Day Center?

☐ Newspaper ☐ Phone Book ☐ Internet

☐ Driving by ☐ Friend/Family ☐ County/Case Manager

☐ Community Event ☐ JFS/JCC/UJFC ☐ Other _____

Participant/Caregiver Signature: _____Date:_____

Participant: _____ DOB:_____

ARBITRATION AGREEMENT

This ____ day of _____, 20____, Sholom Home East, Inc. d/b/a Roitenberg Family Adult Day Center (Facility) and the parties who are signing below agree to arbitrate any disputes arising from Facility's Admission Agreement executed at the same time as this Arbitration Agreement (Agreement) concerning Facility's services and care provided to _____ (Client). It is not a condition of admission for you to agree to this Agreement. If you sign this Agreement, you have 30 days to opt out of and rescind this Agreement.

Binding Arbitration. Arbitration is a way to resolve disputes instead of going to traditional state or federal courts. Instead of a judge or jury deciding the outcome of a dispute, a non-biased and neutral outside party (Arbitrator(s)) chosen by the parties to this Agreement makes the decision. The Arbitrator's decision binds both parties and generally is final and cannot be appealed. The Arbitrator will hear both sides of the story and make a decision based on fairness, law, common sense and the rules established by the arbitration association selected by the parties. When arbitration is binding, it is the only legal process available to the parties. Binding arbitration has been selected because it usually saves time and costs and is easier to use than the courts.

Disputes. A Dispute is any controversy, dispute, disagreement or claim of any kind that has to do with or relates to the Admission Agreement or any service or health care provided by Facility to Client. This means that Client and Facility will not be able to bring or start a lawsuit in any court and are giving-up all rights to a jury trial to decide any Disputes that Client may have against Facility or Facility may have against Client. The arbitration shall be administered by the American Arbitration Association (AAA) in accordance with its Rules of Procedure. Also, judgment on any award given by arbitrator(s) may be entered in any court having appropriate jurisdiction. Client and/or Client's Representative acknowledge(s) and understand(s) that there will be no jury trial on any claim or dispute submitted to arbitration, and Client and/or Client's Representative relinquish and give up their rights to a jury trial on any matter submitted to arbitration under this Agreement.

All Disputes will be decided by binding arbitration except for:

1) guardianship and/or conservatorship proceedings resulting from the alleged incapacity of the Client;

2) collection actions started by Facility for non-payment or failure of Client or Client's representatives to fulfill their obligations under the Admission Agreement (including collections in estate proceedings when the Client has died); and

3) disputes involving total claimed money amounts that can be brought in small claims court.

Apart from these exceptions, this means all Disputes will be decided by binding arbitration including:

- Contracts (including the Admission Agreement);

- Property damage and/or loss;

- Personal injuries sustained by Client including inadequate care or any other cause or reason;

- Wrongful death; and

- Medical malpractice.

Facility agrees to abide by the proper standard of care as provided by state and federal law and this Agreement does not waive Facility's liability for Client's health and safety while Client resides at Facility.

Right to Legal Counsel. Client has the right to be represented by legal counsel in any proceeding initiated under this Agreement. Because this Agreement addresses important legal rights, Facility encourages and recommends Client and/or Client's Representative obtain the advice and assistance of legal counsel to review the legal significance of this binding Agreement before signing this Agreement.

Location of Arbitration. The Arbitration will be conducted at a site selected by Facility which shall be either at Facility or somewhere within a reasonable distance of Facility.

Time Limitation for Arbitration. Any request to arbitrate a Dispute must be submitted to AAA before two (2) years from the date the event giving rise to the dispute occurred. In the event AAA is unable or unwilling to serve, then the request for Arbitration must be submitted to Facility within thirty (30) days of receiving AAA's notice of unwillingness or inability to serve as arbitrator. If this happens, Facility shall select an alternative neutral arbitration service within thirty (30) days after receiving AAA's notice and the selected arbitration service's procedural rules shall apply to the arbitration proceeding. If either party fails to submit a request for Arbitration to AAA or an alternate neutral arbitration service selected by Facility within the two (2) year period, then the party may not and cannot make any more requests for Arbitration or bring any claims or any action or legal proceeding of any kind or nature. This means if the time to request to arbitrate has passed, the parties will be forever barred from arbitrating or litigating a resolution to any such dispute.

Limitation on Damages and Allocation of Costs for Arbitration. The parties equally share the costs of the arbitration and each party is responsible for their own legal fees and costs.

Other Agreements. This Agreement shall bind the heirs, executors, administrators and assigns of all persons signing it.

Signatures to Arbitration Agreement:

Dated: _____ _____

Signature of Facility Representative

_____

Title

Dated: _____

_____
Signature of Client

Dated: _____

_____
Signature of Client's Legal Representative

The relationship between the Legal Representative and the Client is that of:

☐ attorney-in-fact;
☐ conservator of: ☐ the person ☐ of the estate;
☐ guardian of: ☐ person ☐ of the estate.

Address:

_____

_____

Telephone: _____

Initials of Legal Representative _____

NOTICE OF RIGHT TO RESCIND
BINDING ARBITRATION CLAUSE

Date rescission period begins _____.

You may rescind and terminate the Arbitration Agreement (Agreement) without penalty or forfeiture within thirty (30) days of the above date. No other agreement or statement you sign shall constitute a waiver of your right to rescind the Agreement within this thirty (30) day period. To rescind the Agreement, send via certified mail or hand deliver a signed and dated copy of this notice, or any other dated written notice, letter or telegram, stating your desire to rescind to the following address:

Sholom Home East, Inc.
d/b/a Roitenberg Family Adult Day Center
730 Kay Avenue
Saint Paul, MN 55102

not later than midnight of _____ (last day for rescission). If you are rescinding the Agreement via certified mail, the notice must be post marked within thirty (30) days of the date the rescission period begins.

Pursuant to this Notice, I hereby rescind the Agreement regarding binding arbitration with Facility.

Dated: _____

_____
Client's Name

_____
Signature of Client

Dated: _____

_____
Client's Legal Representative's Name

_____
Signature of Client's Legal Representative

Roitenberg Family Adult Day Center

Participant File

Medication Requirements Administering & Self-Administering

Participant Name _____

PROCEDURE: FOR PARTICIPANT SELF-ADMINISTERING OF MEDICATION:

1. Participant will sign the Waiver below.
2. Participant will bring the appropriate medications to Roitenberg Adult Day and have staff lock medication in the medication drawer.
3. Participant will be responsible for taking the medications at the correct time.

☐ SELF ADMINISTERING OF MEDICATION

I hereby request to self-administer medication as prescribed by my doctor. I will keep my medication locked in my locker and will not share these with other clients. I will not hold Roitenberg Family Adult Day Center staff responsible for my medication administration.

_____

PARTICIPANT/RESPONSIBLE PARTY SIGNATURE DATE

_____

STAFF SIGNATURE DATE

PROCEDURE: FOR STAFF ADMINSTRATION OF MEDICATIONS:

1. Each prescription must be brought to Roitenberg AD in its prescription bottle, with the current prescription label on it or the medication is in a bubble pack prepared by a pharmacist. Pharmacies will provide an empty medication bottle with the current prescription label on it when it is requested.
2. This label must match the current information completed by the physician on the Medical Summary form.
3. Each prescription bottle should have one month supply equal to the number of days the client will attend Roitenberg AD that month.
4. If the physician changes the prescription for any reason, Roitenberg AD must be notified immediately concerning the change.
5. The empty bottle will be sent home to be refilled. This must be returned to Roitenberg Adult day in order for the medication to continue to be administered at the adult day program.

☐ STAFF ADMINISTERING OF MEDICATION

I hereby request and authorize Roitenberg Family Adult Day Program staff to assist with administration of my medications as prescribed by my doctor. My medication will be secured by staff and administered to me at the indicated time according to the medication schedule provided. I understand that I am responsible for the procedural requirements listed above and that day center staff are not responsible for procuring my medications.

_____

PARTICIPANT/RESPONSIBLE PARTY SIGNATURE DATE

_____

STAFF SIGNATURE DATE

Roitenberg Family Adult Day Program

Participant File

Participant Medication List

Participant Name _____

Admission Date _____ **Date** _____

Does the participant take any medications? _____Yes ____No
Is the participant responsible for taking his/her own medications? _____Yes ____No
Will Roitenberg AD staff be responsible for the administering
of medications for the participant at the center? _____Yes ____No

Medications - Please list ALL current PRESCRIPTION and OVER THE COUNTER medications
- Information must be accurate and complete
- Medication to be taken at the Roitenberg Adult Day must be marked with an X

	MEDICATION	DOSAGE	TIME TAKEN	REASON	SPECIAL INSTRUCTIONS
☐					
☐					
☐					
☐					
☐					
☐					
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THE ADULT DAY STAFF ARE NOT RESPONSIBLE FOR INACCURATE OR MISSING INFORMATION.

IT IS VERY IMPORTANT THAT MEDICATION INFORMATION BE UPDATED REGULARLY FOR PARTICIPANT SAFETY, AND MAY BE DONE AT ANY TIME BY CONTACTING ROITENBERG ADULT DAY AT 651-328-2013.

_____

PARTICIPANT/RESPONSIBLE PARTY SIGNATURE DATE

_____

STAFF SIGNATURE DATE

Roitenberg Family Adult Day Center Participant File	Orientation Checklist

Participant Name _____

Admit Date _____

BY SIGNING ON THE LINE BELOW I AM ACKNOWLEDGING THAT I HAVE RECEIVED ORIENTATION PRIOR TO AND DURING THE ADMISSION PROCESS, OR WITHIN 24 HOURS AFTER ADMISSION, INCLUDING:

- Internal and external reporting procedure
- Contact information for the license holder's common entry point
- ADC abuse prevention plan.

I HAVE ALSO RECEIVED THE FOLLOWING INFORMATION IN WRITING DURING THE ADMISSION PROCESS, AND STAFF IN THE ADULT DAY CENTER HAS ANSWERED ALL QUESTIONS TO MY SATISFACTION:

- Overview of the program's services and care provided
- Description of the population the ADC serves
- Description of individual conditions the ADC is not able to serve
- Procedure for reporting a grievance
- Copy or summary of Minnesota Statute 626.557, Vulnerable Adult Act
- Transportation policy and procedure
- Provision of meals and snacks
- Program fees, billing, payment plans, and options for assistance
- Smoking policy
- Insurance coverage carried by the ADC
- Statement of the ADC's admission and employment policies and procedures
- Terms and conditions of the ADC's DHS license, including description of the population the program is licensed to serve.
- Program's policy on pets
- My rights as a client of the ADC
- Telephone number for the Department of Human Services, Division of Licensing: 651-431-6600

_____

PARTICIPANT/CAREGIVER SIGNATURE DATE

_____

ADC STAFF SIGNATURE DATE

Roitenberg Family Adult Day Center
Participant File

Participant Bill of Rights

1. All participants have a right to be treated with dignity and respect for their individuality.
2. All participants have a right to live, learn, work and enjoy life in the community.
3. All participants have a right to appropriate care designed to enable them to achieve their highest level of social functioning.
4. All participants shall have the right to participate in the planning and carrying out of their goals and objectives for the program.
5. All participants shall have a choice of activities and have the right to refuse to participate in any given activity.
6. All participants shall be free from physical and mental abuse as defined in the Vulnerable Adults Protection Act.
7. All participants shall have the right to respectful treatment and privacy as it relates to their medical and personal care program.
8. All participants shall be assured confidential treatment of personal and medical records, and may approve or refuse their release to any individual outside of the Sholom Community Alliance.
9. All participants shall be informed, prior to or at the time of admission to the Day Center, of all services which are included in the daily rate as well as other services that are available for an additional fee.
10. All participants shall have the right to prompt and reasonable responses to questions and concerns, and have the right to present grievances regarding treatment or care according to the grievance procedure discussed during the Day Center admission process.
11. All participants shall have the right to every consideration of their privacy, individuality, and cultural identity as it relates to social, religious, and psychological well being.
12. All participants shall be encouraged to understand and exercise these rights as participants and citizens.
13. All participants shall not perform labor or services for Sholom Community Alliance or the Day Center unless those activities are included for therapeutic purposes AND are appropriately goal-oriented with documentation in their individual care plans.
14. All participants, guardians, or caregivers shall have the right to contest the accuracy and completeness of the data in their record.
15. All participants have the right to protection from any non-therapeutic conduct or procedures which might cause non-accidental pain, injury, mental, and/or emotional distress. No participant shall be subjected to coercion or the Emergency Use of Manual Restraints.

_____

Client or Responsible Party Signature Date

Roitenberg Family Adult Day Center	Receipt of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Participant Name _____

For signature by participant or person acting on behalf of Participant

By signing below, I acknowledge receipt of the Roitenberg Family Adult Day Center's current Notice of Privacy Practices on the date of _____ - if this line is blank, the date first set forth in the Admission Agreement will be used.

_____ _____

Participant Signature

Responsible Party Signature
(Includes legal representative, guardian, conservator, attorney in fact under POA, and designated responsible party acting on participant's behalf.)

For completion by Roitenberg Family Adult Day Center staff

If the participant or person acting on behalf of participant fails to sign this receipt of Notice of Privacy Practices, a Day Center representative shall complete the following by initialing, dating, and providing additional information where appropriate.

The Roitenberg Family Adult Day Center provided its Notice of Privacy Practices to

☐ PARTICIPANT

☐ PERSON ACTING ON BEHALF OF PARTICIPANT

☐ _____

on or before the participant's first day of service (Date _____). The person to whom the Notice of Privacy Practices was given, as identified above, refused to sign after being requested to do so.

If the written acknowledgement of receipt of the Roitenberg Family Adult Day Center was not obtained for any other reason, specify here.

_____

_____

ADC Staff _____ Date _____

sholom Care. Compassion. Community.

RELEASE FORM

I hereby consent to the use of my photograph(s) (and/or any copies of my photograph(s) and my name in promotional materials produced and/or published by Sholom, such as:

1. **Official publications, documents, programs, and presentations of Sholom**

2. **Printed communicative media (e.g., newspapers) for promotional use of Sholom**

3. **Electronic communicative media (e.g., worldwide website) for promotional use of Sholom**

I understand that signing this release does not guarantee publication.

_____

Printed Name of Client

_____

Signature of Client or Responsible Party

_____

Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____	_____
Name of Resident/Previous Names	Birth Date/Medical Record Number
AUTHORIZES: (name of releasing organization)	**TO DISCLOSE TO:**
_____	Roitenberg Family Adult Day Center .
Name of Health Care Provider/Plan/Other	Name of Health Care Provider/Plan/Other
_____	730 Kay Avenue .
Street/Mailing Address	Street/Mailing Address
_____	St Paul MN 55102 651-327-2176 .
City, State, Zip Code	City, State, Zip Code Fax #

INFORMATION TO BE RELEASED:
For the following date(s): From:_____ To: _____

X History & Physical Exam	___Interdisciplinary Progress Notes	___X-ray/Diagnostic Imaging Reports
___Interdisciplinary Assessment Notes		___Consultations
	___Laboratory/Pathology Reports	
___Care Plan	___Immunizations	___PT/OT Notes
___Minimum Data Set	X Other Diagnosis/problem list	___Physician's Orders
	-X. Other: Medication List	

PURPOSE OF DISCLOSURE: (CHECK ALL THAT APPLY)

___Further Medical Care	___Vocational Rehabilitation Evaluation	___Personal
___Insurance Eligibility/Benefits	___Legal Investigation or Action	___Changing Physicians
X .Other: Admission to Adult Day program		

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to inspect or copy the health information to be disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting _____'s Privacy Officer. **Right to receive copy of this authorization –** I understand that if I agree to sign this authorization I must be provided with a signed copy of the form. **Right to refuse to sign this authorization –** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclosure my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to revoke this authorization –** I understand written notification is necessary to cancel this authorization. To obtain information on how to revoke my authorization I may contact _____'s Privacy Officer. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that _____ has already made in reference to this authorization.

REDISCLOSURE STATEMENT: I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer by protected by state or federal privacy rules.
EXPIRATION DATE: This authorization will expire one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am authorizing _____ to disclose my above identified protected health information.

RESIDENT/LEGAL REP. SIGNATURE_____ DATE: _____

IF NOT RESIDENT, PLEASE STATE RELATIONSHIP TO RESIDENT:_____

WITNESS: _____ EXPIRATION DATE: _____

Roitenberg Family Adult Day Center
Participant File

Social History

BACKGROUND INFORMATION

Name _____ Maiden Name _____

Birth Date _____ Birthplace _____ Marital Status _____

Living Arrangement - ☐ Alone ☐ Spouse ☐ Family ☐ Other _____

Synagogue/Church _____ Role of Religion _____

FAMILY INFORMATION

Mother's Name _____ Country of Origin _____

Father's Name _____ Country of Origin _____

Brothers' Names/ Locations _____

_____

Sisters' Names/ Locations _____

_____

Spouse's Name _____ Birthplace _____

Date Married _____ Occupation _____ Death/Divorce? _____

Other marriage information _____

Name(s) of Children _____

_____ # of Grandchildren _____

Involvement of Family _____

Other Significant People in Participant's Life _____

_____

EDUCATION AND WORK HISTORY

High School _____ College/University _____

Degree(s) _____ Other special training _____

Primary Occupation _____ Retirement Date _____

Other Work Experience _____

Organizational Memberships _____

SOCIAL/EMOTIONAL FUNCTIONING

Leisure Time/Hobbies: _____

☐ Cards	☐ Crafts	☐ Table Games	☐ Newspaper/Books	☐ News Talk/TV
☐ Music/Radio	☐ Art	☐ Animals/Pets	☐ Sports	☐ Exercise

☐ Sewing/Knitting ☐ Jigsaw Puzzles ☐ Word Games ☐ Cooking ☐ Gardening

☐ Picnics ☐ Movies ☐ Outings ☐ Socializing ☐ TV Programs

Significant Life Experiences (trips, awards/honors, achievements, losses, crises, etc.) _____

_____

Personality Traits/Characteristics: _____

_____

Communication Pattern: _____

_____

Decision Making: _____

_____

MISCELLANEOUS

Prior Experiences - ☐ Senior Center ☐ Adult Day Center ☐ Assisted Living ☐ DD Case Mgmt eligible

Reason for Referral _____

_____

Participant's reaction to plans for adult day services _____

_____

Home Services in place _____

_____

Other information important for the Day Center staff to know about this participant:

_____

_____

_____

_____

_____

ADC Staff _____ **Date** _____

Roitenberg Family Adult Day Admission Needs Assessment

Name_____Diagnosis_____

ACTIVITIES OF DAILY LIVING

WALKING
☐Independent
☐Independent with device (walker, cane)
☐Assist of 1 (T-belt, stand-by)
☐Unable to ambulate

WHEELING
☐Independent
☐Dependent
☐Occasional Assist

GROOMING
☐Independent
☐Supervision
☐Assist

BOWEL
☐Continent
☐Incontinent
☐Colostomy
☐Hx bowel disorder

TRANSFERS
☐Independent
☐Assist of 1

DRESSING
☐Independent
☐Dependent
☐Assist
☐Supervision

EATING
☐Independent
☐Assist
☐Cut up foods
☐Adaptive utensils

TOILETING
☐Independent
☐Need Reminder
☐Assist of 1

PSYCHOSOCIAL

ORIENTATION
☐Alert
☐Oriented to:
☐Person
☐Place
☐Time
☐Forgetful

BEHAVIOR
☐No Problem
☐Need Redirection
☐Withdrawn
☐Agitated
☐Wanders
☐Combative/Abusive

FALL RISK SCREENING
☐Fall in last 6 months_____
☐Resulting Injuries_____
☐Admission related to fall
☐More than 5 meds prescribed

MOTIVATION
☐Willing to attend
☐Anxious about attending
☐Reluctant to attend

DIAGNOSIS/CONDITION
☐Hx Cardiac Dx ☐Diabetes
☐Hx Infection ☐Insulin Dependent
☐Hx CVA ☐Alzheimer's
☐HTN ☐Pain ☐DD Case eligible
☐Dementia

PHYSICAL STATUS

VERBAL COMMUNICATION
☐WNL
☐Impairment
☐Aphasia
☐Primary language: English

SKIN CONDITION
☐Intact Hx Shingles
☐Pressure Sore
☐Rash
☐Dressings

RESPIRATION
☐Normal
☐SOB
Explain:_____

HEARING
☐WNL
☐Hearing impaired
☐Hearing aid (R, L)

CURRENT THERAPY
☐PT ☐ROM Exercises
☐OT ☐Speech
☐Future interest

DIET
☐Food allergy_____
☐Regular ☐Mech Soft
☐Puree ☐Other_____

DENTAL
☐None
☐Natural
☐Upper/Lower dentures

VISION
☐WNL
☐Vision Impaired
☐Glasses

MEDICATIONS
☐Self-administered @ Sholom
☐Administered @ Sholom
☐Instructed must be labeled
☐At home only

ROLE OF PARTICIPANT'S CAREGIVER:

_____
_____

REASON FOR ADMISSION TO DAY PROGRAM:

_____
_____

DAYS OF ATTENDANCE
☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Hours of attendance:_____

PERSONAL CARES
☐Shower ☐Beauty Shop

APPROPRIATE FOR ADMISSION
☐Yes ☐No

CAREGIVER NOTIFIED OF THIS ON:_____

COMMENTS:_____
_____
_____
_____
_____

_____
CLIENT/CAREGIVER SIGNATURE **DATE**

_____
INTAKE STAFF SIGNATURE **DATE**

Dear Roitenberg family/caregiver,

From time to time, we would like to take our Roitenberg ADC clients for a ride in the community. We may use the Sholom bus and take a ride around the lakes, or just get into our personal cars and go to the library or the store. There will be no cost for the ride, but you will need your own spending money.
We need to have your written permission for these outings. Please complete the bottom of this letter and return it to Roitenberg Family Adult Day Center as soon as possible. And rest assured, drivers of all vehicles are trained drivers and have appropriate insurance.
Please check the appropriate statement.

_____ I give my permission for _____ to go on car or van rides with Roitenberg Adult Day Center.

_____ I deny my permission for _____ to go on car or van rides with Roitenberg Adult Day Center.

_____
Caregiver or Client printed name

_____
Caregiver or Client signature

_____
Date

David Feinberg Vitality and Aquatics Center
SHALLER FAMILY SHOLOM EAST CAMPUS
730 Kay Avenue, St. Paul, MN 55102
Phone (651) 328-2051; Fax (651) 328-2176

Release Form

Use of Sinykin Wellness and Exercise Room, the Garelick Family Fitness Center and Participation in Wellness Classes

Even when performed appropriately and under proper supervision, there are inherent risks with using any exercise equipment and participating in any exercise program. As a condition of my use of the facilities and exercise equipment located at, including participation in exercise classes offered through the David Feinberg Vitality and Aquatics Center ("Center"), I am knowingly assuming these risks.

I understand that this is an **important legal document** and that it is critical that I have read it thoroughly and understand it completely.

Assumption of Risk

I understand that I will be instructed in the proper technique and use of the facilities and equipment authorized for my use and that it is my right to have all questions answered to my satisfaction. I understand that it is my responsibility to follow the health and safety guidelines as established by the Center staff. I understand that it is also my responsibility to immediately inform Center staff of any discomfort or pain that occurs during or after my use of the facilities or equipment. I understand that the use of the facilities and equipment is a potentially hazardous activity. It is not possible to specifically list each and every risk; however, fitness activities do involve risk of injury including: muscle strains or sprains, fatigue, other bodily injury, alteration in blood pressure or heart rate, fainting, heart attack, stroke, drowning, and a risk of disability or death. I hereby agree to expressly assume and accept any and all risks of injury or death.

I do hereby further declare that I am not suffering from any condition, impairment, disease, infirmity, or other illness that would prevent my use of the exercise facilities or equipment. I also acknowledge that the Center recommends that I have yearly or more frequent physical examinations and consultations with my physician as to physical activity, exercise, and use of exercise facilities, equipment, or participation in exercise classes. I acknowledge that I have either had a physical examination and have been given my physician's authorization to utilize the facilities and equipment, or that I have decided to use the facilities and equipment without the approval of my physician. In either case, I acknowledge that I assume all responsibility for my use of the facilities and exercise equipment and participation in exercise classes.

Indemnification and Waiver of Liability

In consideration of using the exercise facilities and equipment located at the Center and/or participation in exercise classes offered by the Center, I do hereby waive, release, and forever discharge the Center and its owners, managers, directors, officers, employees, representatives, agents, subcontractors, affiliates, successors, and assigns from any and all responsibility or liability for injuries or damages resulting from my use of said facilities and equipment and/or participation in exercise classes.

Further, I do hereby and forever release, discharge and hold harmless the Center and its owners, managers, directors, officers, employees, representatives, agents, subcontractors, affiliates, successors, and assigns from any and all claims, demands, damages, rights of action, or causes of action, present or future, in any way arising out of or connected with my use of the facilities and exercise equipment and/or participation in exercise classes, including any injuries resulting therefrom. This waiver and release of liability includes, but is not limited to, injuries which may occur as a result of equipment that may malfunction or break; any slip, fall, or dropping of equipment or unintentional oversight; and any inappropriate usage of the equipment.

Informed Consent

I fully understand the risks and waivers set forth herein, have had the opportunity to have this document reviewed by counsel of my choice, and knowingly agree to accept full responsibility for my own exposure to such risks and to give the Indemnification and Waiver of Liability set forth above. I specifically acknowledge that I will not be under the direct supervision of Center staff while using the facilities or equipment, or while participating in exercises classes, including while utilizing the swimming pool. I acknowledge that I have thoroughly read this document, and I am aware that I am waiving any right I, or my heirs, successors or assigns, might have to bring a legal action or assert a claim against the Center and the others noted above in the Indemnification and Waiver of Liability section of this document, in the case of any injury or other harm.

Date: _____

Printed Name: _____

Signature: _____

David Feinberg Vitality and Aquatics Center
SHALLER FAMILY SHOLOM EAST CAMPUS

730 Kay Avenue, St. Paul, MN 55102
Phone (651) 328-2051; Fax (651) 328-2330

Aquatic Activities
Release of Liability

Name of Participant: _____
Address: _____
Phone: _____

The terms "me", "my" or "I" means the Participant signing below who signs on the Participant's own behalf, or a Participant who is a minor child or ward of the individual signing below on behalf of the Participant. The term "Aquatic Activities" includes all my use of the David Feinberg Vitality and Aquatics Center ("Aquatics Center"), including but not limited to the warm water therapy pool ("Pool"), areas around the Pool, equipment, changing facilities, parking areas, lobby areas, and any other areas of the Shaller Family Sholom East Campus I may use on my way to or my way from the Aquatics Center.

I. ASSUMPTION OF RISKS

I am aware that the Aquatic Activities that I will participate in at the Aquatics Center takes place in a Pool environment and involves various risks, dangers and hazards and the possibility of personal injury, death and loss of property, some of which may be expected or anticipated, and others of which may be unexpected and unanticipated. To a large extent, these risks, dangers and hazards derive from the challenging nature of the activities and the Pool environment in which they take place. I have been strongly encouraged to consult directly with the Aquatics Center staff in order to gain a full appreciation of the risks, dangers and hazards associated with these activities. I acknowledge that the Pool is 3 to 5 feet deep.

These risks, dangers and hazards include but are not limited to: accidents which occur during transportation or travel to the Pool area where the activities take place; Pool accidents including slipping on Pool deck, collisions in Pool involving end of Pool or other users; and contraction of diseases and infections, cuts, nosebleeds, burns, stings, rashes, head injuries, injured or broken limbs, paralysis, death, and other similar hazards. Further risks, dangers and hazards may arise through purposeful acts or negligence of other participants or other individuals, including Aquatic Center staff and volunteers, including but not limited to: theft of personal property and invasion of privacy. I acknowledge that these are only some examples of the risks, dangers and hazards I may encounter during participation in Aquatic Activities.

I further acknowledge that the Aquatic Center does not provide staff to safeguard or protect me from any of the risks, dangers, or hazards, including preventing individuals with communicable diseases from utilizing the facilities or supervising the activities of other individuals.

I AM AWARE OF THE RISKS, DANGERS AND HAZARDS ASSOCIATED WITH PARTICIPATING IN THE AQUATIC ACTIVITIES AND I HEREBY FREELY ACCEPT AND FULLY ASSUME ALL RISKS, DANGERS AND HAZARDS AND THE POSSIBILITY OF PERSONAL INJURY, DEATH, PROPERTY DAMAGE OR LOSS RESULTING THEREFROM.

II. RELEASE OF LIABILITY, WAIVER OF CLAIMS AND INDEMNITY AGREEMENT

In consideration of the Aquatics Center permitting me to participate in the Aquatic Activities and for other good and valuable consideration, the receipt and sufficiency of which is acknowledged, I hereby further agree as follows:

1. **TO WAIVE ANY AND ALL CLAIMS** I have or may in the future have against Sholom Community Alliance, d/b/a David Feinberg Vitality and Aquatics Center, and all its directors, officers, employees, agents, instructors, independent contractors, representatives, successors, and assigns ("Sholom") **AND TO RELEASE** Sholom from any and all liability for any loss, damage, expense or injury including death I may suffer, or that my next of kin may suffer as a result of my participation in the Aquatic Activities, **DUE TO ANY CAUSE WHATSOEVER, INCLUDING NEGLIGENCE, BREACH OF CONTRACT, OR BREACH OF ANY DUTY OF CARE, ON THE PART OF SHOLOM, AND FURTHER INCLUDING THE FAILURE BY SHOLOM TO SAFEGUARD OR PROTECT ME FROM THE RISKS, DANGERS AND HAZARDS OF ANY AQUATIC ACTIVITIES, INCLUDING TO WAIVE MY RIGHT TO BRING LEGAL ACTION NOW OR AT ANY TIME IN THE FUTURE TO RECOVER COMPENSATION OR OBTAIN ANY OTHER REMEDY FOR ANY INJURY TO MYSELF OR MY PROPERTY, HOWEVER CAUSED;**

2. **TO HOLD HARMLESS, INDEMNIFY, AND DEFEND** Sholom from any and all liability for any property damage or personal injury to any third party resulting from my participation in the Aquatic Activities;

In entering into this Agreement, I am not relying on any oral or written representations or statements made by Sholom with respect to the safety of the Aquatic Activities, other than what is set forth in this Agreement. I expressly agree that this release is intended to be as broad and inclusive as allowed under the State of Minnesota and that, if any portion is held invalid, I agree that the balance shall, continue in full legal force and effect.

I AM VOLUNTARILY CONSENTING TO ATTEND OR PARTICIPATE IN AQUATIC ACTIVITIES; I HAVE READ AND UNDERSTOOD THIS AGREEMENT PRIOR TO SIGNING IT; I HAVE SIGNED IT OF MY OWN FREE WILL; AND I AM AWARE THAT, BY SIGNING THIS AGREEMENT, I AM WAIVING CERTAIN LEGAL RIGHTS I OR MY SPOUSE, PARENTS, SIBLINGS, HEIRS, ESTATE, NEXT OF KIN, EXECUTORS, ADMINISTRATORS, AND REPRESENTATIVES MAY HAVE AGAINST SHOLOM.

I ALSO AGREE TO COMPLY WITH ALL DIRECTIONS PROVIDED BY STAFF OF THE AQUATICS CENTER AND TO ADHERE TO ALL RULES AND REGULATIONS GOVERNING THE USE OF THE AQUATIC CENTER, INCLUDING BUT NOT LIMITED TO RULES REGARDING SUPERVISION AND CONTROL OF MINOR CHILDREN.

Witness	Signature of Participant Date
Witness	Signature of parent or guardian Date

Adult Day Staff to Complete the Remainder of the Paperwork

Roitenberg Family Adult Day Center **Business Office**

Participant File

New Participant **Billing Change** **Leaving Program**

Name _____ Date _____

Address _____

Date of Birth _____ Social Security Number

_____

Primary Language _____ Religion/Cultural Preference _____

Primary Contact for Finances – Is this contact a POA? Yes No

Name _____ Relationship _____

Address_____

Phone Numbers _____

Other Family Contact – Is this contact a POA? Yes No

Name _____ Relationship _____

Address_____

Phone Numbers _____

Billing Source

☐ **Private Pay** ☐ **Waiver EW AC CADI _____ PMI #**

☐ **VA _____ Last 4 digits of SS#** ☐ **Other**

Circle one: Half Days Full Days

Current Rate of Pay _____ New Rate of Pay _____

Current Transportation Info _____ Monthly Maintenance Fee ☐ **Yes** ☐ **No**

New Transportation Info _____

Current Bathing Plan _____ New Bathing Plan _____

County Case Manager _____ County _____

Phone _____ Program _____

Additional Information _____

_____

ADC Staff _____ Date _____

Date AD staff submitted to Director _____ Submitted to Business Office _____

Roitenberg Family Adult Day Center
Participant File

Medical Summary

Name _____ Date of Birth _____

Physician's Name _____

Clinic Name & Address _____

_____

Phone ( ) _____ Fax ( ) _____

Date of MD visit _____

Does this individual have a Health Care or Financial POA? YES NO

Health History (please include current diagnoses & detailed health history including medical and mental health)

_____

_____

_____

_____

_____

Is individual free from communicable disease or infection? YES NO

Medications (please list ALL current PRESCRIPTION AND OVER THE COUNTER medications – mark the box next to those that will be taken at the ADC with an X)

Is this individual able to self-administer his/her own medications while at the Day Center? YES NO

Is administration of medications by trained day center staff approved for this individual? YES NO

	MEDICATION	DOSAGE	TIME TAKEN	REASON	SPECIAL INSTRUCTIONS
☐					
☐					
☐					
☐					
☐					
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☐					

**Medication Allergies _____

Nutrition/Dietary Needs

Required diet – combinations may be requested. _____ Regular _____ Low NA _____ Mechanical Soft _____ Low Fat _____ Lactose Intolerant _____ 1800 cal. ADA ****Food Allergies** _____	**Can this individual have a regular diet for special occasion or holiday meals?** YES NO

Status Check

VISION	good	average	poor	needs corrective item	_____
SPEECH	good	average	poor	needs corrective item	_____
HEARING	good	average	poor	needs corrective item	_____
BALANCE	good	average	poor	needs corrective item	_____
SWALLOWING	good	average	poor	_____	
PROBLEM SOLVING	good	average	poor	_____	
SAFETY/AWARENESS	good	average	poor	_____	
SUPPORT SYSTEM	good	average	poor	_____	

The ADC conducts a daily exercise program from a seated position. Is this individual able to participate? YES NO

Please specify any precautions or restrictions relating to exercise or physical exertion:

_____

_____

_____

Any other information you feel would be beneficial to ADC staff prior to admission to the center –

_____

_____

_____

DO YOU RECOMMEND THIS INDIVIDUAL FOR ADULT DAY PROGRAMMING? **YES NO**

Physician Name _____ **Date** _____

Physician Signature _____

ADC Nurse Name _____ **Date** _____

ADC Nurse Signature _____

Roitenberg Family Adult Day Program
Standing House Orders

The Standing House Orders (SHO) intent is to provide comfort to the client as the nurse continues to assess the situation.

Client Name	**DOB**	**Doctor Name**

Medication Administration
May crush medications after checking list for crushable medications
May administer medications with foods

Insulin Reaction –S/Sx of Hypo or Hyperglycemia
Obtain blood glucose reading
Administer 3-4 ounces orange juice with 2 packets of sugar for Hypoglycemia

Cough/Sore/Throat
Robitussin DM (or generic equivalent) 10cc po q 4 hours PRN cough
OTC cough drops/throat lozenges per package directions.

Indigestion/Reflux
Maalox (or equivalent) 30cc po q 2 hours PRN: not to exceed 3 doses in 24 hours

Pain or Discomfort
Acetaminophen 325-650mg q 4 hours PRN oral
Warm/Cold pack applied, on for 15min, off for 15min

Skin Tears
Cleanse wound with wound cleanser-Approximate edges-Apply dressing-Change PRN.

Constipation
MOM 30cc po qd PRN

Diarrhea
Immodium 4 mg po: May repeat 2 mg after each loose stool to a maximum of 8 mg in 24 hours (1mg/tsp)

Diet
May adjust consistency of diet from regular to softer consistencies as needed
May have house supplement as required to supplement nutrition

Nose bleed
Apply ice pack and pressure to nose for at least 5 min

MD Signature	**Date**

ROITENBERG FAMILY ADULT DAY CENTER

Participant File

Preliminary Service Plan

Name _____ Admission Date _____

Scheduled Days

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

Hours _____

POA/Guardian/Case Manager? _____

Transportation Plan _____

_____

MM Contacted? Yes No

Nutritional Needs _____

_____

Kitchen Notified for special nutrition orders? Yes No

Role of Caregiver _____

_____

Resources Offered? Yes No

Special Services Required _____

_____

Bath Scheduled? Yes No Therapy Contacted? Yes No

Activity Participation _____

_____

Attend Activities? Yes No Attend Outings? Yes No Enjoy Music? Yes No

Additional Information _____

_____

_____

_____

ADC Staff _____ Date _____