Admission Packet

The mission of More to Life Adult Day Health Center is to provide a safe and friendly group care program for dependent adults during the day. The club provides a comfortable and encouraging environment with a wide variety of activities to enrich the lives of each participant. The program is designed to maintain the participants' highest level of independence and well-being, and to meet the needs of frail or impaired adults over 18 years old, including those with traumatic brain injuries, stroke, Alzheimer's and other forms of dementia. The program provides an economical alternative that enables families to remain together longer while extending independence and offering "More to Life" for the recipient and the caregiver.

Other Documents to be completed

Client Medical Report - (Please have Doctor's office complete and return to MTL)

TB Test Consent form

Updated 2/2/17

Instructions

1. Please feel free to ask for assistance. Call 775-358-1988

2. After completing the forms, return the packet to the Director of More to Life.

3. Pay the admission/processing fee.

4. Get a Client Medical Report and submit the report. Form is included in this packet.

5. Complete step one of the TB Test (skin test for tuberculosis) .

6. Return 48 to 72 hours later to have the test read and recorded.

7. Bring a copy of the negative results to More to Life and join the program.

8. State requires a second TB test 1 to 3 weeks later, after participant is attending MTL.

The information you provide in this packet is extremely helpful in providing the custom care plan and the most beneficial activity program for the participant.
This information will be kept confidential**.**

More to Life Adult Day Health Center, LLC
1963 East Prater Way
Sparks, NV 89434
Phone: 775-358-1988
Fax: 775-358-1588
Info@moretolifeadhc.com
www.MoreToLifeADHC.com

Certifications

Nevada State License: NV20101030866
Bureau of Health Care Quality and Compliance License: 5907ADC-9
Sparks City License: 069094
State Health Permit: WA-02-10113
ServSafe Certificate: 11969268

More to Life Application for Enrollment

The information you provide in this form is extremely helpful in providing the custom care plan and the most beneficial activity program for the Client. Please print clearly.

Client name (the one to receive care at More to Life)_____date:_____
Preferred name:_____
How did you learn about More to Life?_____

Please **circle five** aspects about More to Life that you feel will help the client the most.

enriching activities	peer support and friendship	transportation
nutritious lunch/snacks	shower, bathing	incontinence management
friendly staff	licensed nurse	patio gardening
wellness monitoring	secure facility	exercise program
financial aid	caregiver support	affordable rates
Saturdays/holidays	communication board	fall reduction
manicure, pedicure	med reminders	hair cut, color, set
limo tours	laughter yoga	musical performances
walking club	men's group	Spanish

Responsible party:

Name_____ Relationship to client:_____
Physical address: Street:_____City:_____State:____Zip:_____
Billing address: Street:_____City:_____State:____Zip:_____
E-mail address_____
Phone Home:_____ Cell:_____ Work: _____
Employer:_____ Driver License #:_____
Please note that we will use the Home number to leave messages if there is no answer.

Client Info:

Physical address Street:_____City:_____State:____Zip:_____
Date of birth ____/____/_____ SSN _____-_____-_____ (required by state)
Military affiliation_____Ethnicity:_____ Religion:_____
Emergency contact Name_____Relationship_____ Phone _____
Other relatives or friend for emergency contact (or to help in conversations):

Name	Relationship	City/State	Phone number

Program attendance of at least twice a week is required for noticeable improvement.
Desired client attendance schedule: M T W TH F S Start time _____ Depart time_____
Transportation to and from center:
Family vehicle _____
RTC ACCESS Bus_____ (Ask for application packet if not already using RTC)
More to Life Limo _____ (See page 11 for fee details)

Client Medical Information

Client name:_____

Primary care physician _____ phone_____ fax _____
Hospital preference _____
Primary Diagnosis_____
Approximate date of onset_____
Describe other major illnesses:_____
Personality: easy-going, often agitated, enjoys people, etc._____
Bladder continent? Yes/No_____ Needs help in restroom?_____
Bowel continent? Yes/No_____ Needs help in restroom?_____
Catheter? Special needs:_____
Glasses? Yes/No_____ reading_____ distance_____ all the time_____
Hearing aid? Yes/No_____ right ear_____ left ear_____ both ears_____
Dentures? Yes/No_____ partial_____ complete_____
Does participant remove dentures after eating? Yes/No_____
Cane, Walker, Wheelchair, not a fall-risk (circle one)
Oxygen use at center? Yes/No If yes, please provide Doctor's order for frequency and flow rate.
Does participant smoke? Yes/No If yes, how often?_____
Current use of alcohol or other addictive substance? Yes/No If yes, how often?_____
Food Allergies_____
Allergies to Medicines_____
Other allergies_____
Diet restrictions _____

Medications to be take while at Center:
(We encourage medications to be taken at home if at all possible.)

Name of medication	Reason prescribed	Dose and Instructions	date begun

I authorize staff of More to Life to remind or administer prescribed medication at the center.
Responsible party signature:_____ Date:_____

Please identify any changes in the recent months relative to the following:

Repetitive questioning	Y_____ N_____
Wandering	Y_____ N_____
Memory loss	Y_____ N_____
Has client had any falls in the last three months?	Y_____ N_____
If yes, how many times? _____	
Do you see any loss of balance or unsteadiness when client walks?	Y_____ N_____
Have you noticed any weakness?	Y_____ N_____
Does client have difficulty getting up from a chair or toilet?	Y_____ N_____
Can client walk 50 feet without appearing fatigued?	Y_____ N_____
Does the client complain of any pain? If yes, where? _____	Y_____ N_____

Additional Information:
_____
_____

Social History

Client name:_____

The information you provide in this form is extremely helpful in providing the custom care plan and the most beneficial activity program for the Client.

General Information about Client:

Name of Spouse_____ living? Yes/No_____
Place of Birth_____
State/Countries lived in_____
Favorite topic of discussion _____
Travel Experience_____
_____

School and Work History

College?_____
Favorite subjects in school_____
Former Occupations_____ _____
Attitude toward work (like/dislike)_____
Languages_____
Does client read?____ books _____ kinds of books _____ magazines_____ newspaper_____

Personal Interests

Hobbies/interests_____
Recreation: outdoors_____ indoors_____
Favorite food_____
Favorite sports team(s)_____
Play any musical instruments:_____
Favorite music_____performer:_____song:_____
Favorite performer or movie star_____
Favorite movie_____
Other skills/talents (art, sports, singing, etc.) _____
_____
_____
Club/Organizations/Church _____

Family Goals and Information

Family's impression of major strengths_____
What are the goals of the client?_____
What type of positive reinforcement may motivate client?_____
Any topics of discussion to be avoided?_____
Any sensitive topics we should know about?_____
_____

Responsible party signature:_____ Date:_____

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More to Life Policies and Client Agreement

Initial:_____

PROGRAM POLICY

- These policies are based on respect, cooperation, confidentiality and safety of our clients.
- Client must not require any form of restraint or sedative unless ordered by a physician.
- Client must not pose a danger to self or others. Clients engaging in disruptive behavior are subject to dismissal from the program following written notification.
- Clients will be discharged or referred to other programs if their needs cannot be met by More to Life or if the Client or Responsible party is in violation of this agreement.
- Client may be incontinent and require staff assistance with toileting. Scheduled bowel and bladder programs are arranged for clients willing to participate.
- More to Life is a smoke-free facility. Smoking is only permitted in the outside designated area.
- A change of clothes and some disposables should be kept at the facility in case of an accident.
- Clients are served a noon meal, meeting 1/3 of the RDA requirements and approved by a certified dietician. Additional nourishment is provided mid-morning and mid-afternoon.
- The management of More to Life agrees to exercise the best of care for its clients, however, More to Life is in no sense an insurer of the client's safety or welfare and assumes no liability as such.
- More to Life will not be responsible for any valuables or money left in the possession of participants while the client is at the facility.
- Pursuant to Title VI of the Civil Rights Act of 1961, More to Life is nondiscriminatory. Religion, race, national origin, age or gender will not be considered in client admission process or treatment following admission.

Initial:_____

MEDICATION POLICY

- Medication taken at More to Life will be administered by the nurse on duty or self-administered as reminded by staff according to physician's orders. Records will be kept accordingly.
- All medications must be provided in the fully labeled containers in which they were dispensed. A secure area will be provided for client's medication.
- Clients are not permitted to possess medications while in the facility. The consequences of any violation of this policy will be the responsibility of the responsible party.

- Client or Responsible party is required to update the Director at More to Life of any changes in medications or physician's orders.

- In case of Emergency Responsible party grants permission for any treatment for the Client that a physician deems necessary.

Initial:_____

ILLNESS POLICY

- Client must have a physical examination conducted by a physician, physician's assistant or nurse practitioner, within six months prior to admission into the More to Life program. The updated physical along with a complete medical history and any dietary restrictions must be provided before the first day of attendance.

- Client must have the first step complete of a 2-step TB test with negative results or a negative chest x-ray and must not have any of the following symptoms:
  1. Has had a cough for more than 3 weeks,
  2. Has a cough which is productive,
  3. Has blood in the sputum,
  4. Has a fever which is not associated with a cold, flu or other apparent illness,
  5. Is experiencing night sweats,
  6. Is experiencing unexplained weight loss, or
  7. Has been in close contact with a person who has active tuberculosis.

- Client is not permitted to attend the program if they have had a fever in excess of 100°F, uncontrollable diarrhea or vomiting within the previous 48 hours.

- Responsible party agrees to notify the More to Life Management immediately if Client or Caregiver are exposed to or contract a communicable disease.

- If the Client is hospitalized or absent from MTL for more than 30 days, the Responsible party must bring a written note from the doctor stating the date the Client can safely return to the program, along with any special instructions.

Initial:_____

FINANCIAL POLICY

- Invoices are sent out the 1st and the 15th of the month for services rendered. Clients enrolled for alternate sources of funding will have invoices sent to the respective agencies.

- Payments are due upon receipt of invoice. Unpaid invoices will bear an interest rate of 18% APR, or the maximum allowable by law, from due date until paid. The responsible party will be responsible for all charges incurred at MTL including those not covered by insurance or other financial support and all costs associated with payment collection.

- The Responsible party agrees to pay $40 for every returned check.

Initial:_____

PRIVACY POLICY

- MTL (More to Life Adult Day Health Center, LLC) arranges some activities that may involve visitors to the center, which will sign confidentiality statements disclosing that they may not discuss or repeat any client or personal information they may see or hear while visiting MTL. Monthly calendars are posted on the bulletin board and on the MTL website for your review and appropriate planning of events.

- MTL uses health information about the client to provide services, to obtain payment for services, for administrative purposes, and to evaluate the quality of client care. Client health information is contained in a file that is the physical property of MTL and is always stored in a secure manner.

- MTL may use client health information to provide services to the client. For example, MTL will record information related to client service. This information is necessary for and may be transmitted to providers to determine what services the client should receive.

- MTL may use and disclose client health information to others for purposes of receiving payment for services. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies the client, diagnosis, and service or supplies used in the course of service.

- MTL may use and disclose health information for operational purposes. For example, client health information may be disclosed to staff members, risk or quality improvement personnel, and others to: evaluate the performance of our staff, assess the quality of our services, learn how to improve our services and determine how to continually improve the quality and effectiveness of the services we provide.

- Even if an individual has requested additional restrictions on uses and disclosures of health information and MTL has agreed, if the individual is in need of emergency treatment and the restricted protected health information is needed to give the emergency treatment, MTL may use the restricted protected health information, or may disclose such information to a health care provider, to give such treatment to the individual. MTL will require that such health care provider not further use or disclose the information.

- MTL may use client information to contact you about appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- Health information may be disclosed to an individual's personal representative if the person is authorized to act on behalf of an individual, or under the law the person is an executer, administrator or other person with authority to act on behalf of an individual.

- MTL may use and disclose client information as required by law. For example, MTL may disclose information for the following purposes: for judicial and administrative proceedings pursuant to legal authority, to report information related to victims of abuse, neglect or domestic violence, and to assist law enforcement officials in their law enforcement duties.

- Client health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

- Client health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

- MTL may use client health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of health information has approved the research.

- Client health information may be disclosed to avert a serious threat to the health or safety of client or any other person pursuant to applicable law.

- Client health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

- Client health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

- Other uses and disclosures will be made only with your written authorization. You may revoke the authorization except to the extent MTL has taken action in reliance on such.

Client Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures of client health information; however, MTL is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your file;
- Request that your file be amended or corrected;
- Request communications of client health information by alternative means or at alternative locations;
- Receive an accounting of disclosures made of your health information.

Complaints

- You may issue written complaints to MTL or to the Department of Health and Human Services. All complaints will receive an impartial, timely review and prompt corrective action. Assistance with writing the complaint is available if needed. We welcome all complaints or concerns as tools to help us continually improve our program and services.

Obligations of MTL

MTL is required by law to:

- Maintain the privacy of protected health information;
- Provide you with this Notice of its legal duties and privacy practices with respect to client health information;
- Notify you if we are unable to agree to a requested restriction on how client information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and MTL reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon request.

PHOTOGRAPHY POLICY

- The Responsible party authorizes More to Life to photograph, video and/or audio tape the Client for ***clinical*** purposes. (example: ID badge, client file and notable injuries)

Initial:_____ Please initial if in agreement or cross out if not.

- The Responsible party authorizes More to Life to photograph, video and/or audio tape the Client for ***Marketing*** purposes. (example: Web site, publications, advertisements)

Initial:_____ Please sign if in agreement or cross out if not.

ADVANCE DIRECTIVE

Place an X in the spaces ( ) that apply:

( ) Client does not require a Power of Attorney and may sign legal documents independently, Or
( ) Client has a Power of Attorney or Legal Guardian, name:_____Ph:_____

( ) Client has an Advance Directive
( ) Responsible party will provide More to Life with an original of the Advance Directive,

Or

( ) Client does not have an Advance Directive
( ) Responsible party would like information on how to obtain an Advance Directive.

( ) Client does not want an Advance Directive.

( ) Client has a DNR (Do Not Resuscitate) order.

Responsible party will provide More to Life with copies of the above Advance Directive documents in order to support client rights and wishes while at More to Life.

Level of Care

Level 1: Examples of Participant's capabilities or needs:

- Eats independently. No monitoring of special diet or medications.
- Participates in group activities without special modifications or frequent intervention.
- Occasional stand-by assistance to walk or transfer safely.
- Uses toilet without assistance.

Level 2:

- Requires regular supervision and/or assistance in social or personal care activities.
- Requires frequent intervention.
- Requires assistance with ambulation, transferring, catheter, toileting or feeding.
- Requires special diet, medication or Oxygen.

Fee Schedule

Program Rates

	(Weekdays & Holidays)		(no lunch)	
	7:00 – 5:30	**7-1 or 12-5**	**7-12 or 1-5**	**9:00 – 4:00**
	Full Day	**Half Day +**	**Half Day**	**Saturdays**
Level 1:	$ 64	$ 49	$ 39	$ 64
Level 2:	$ 84	$ 59	$ 49	$ 84

These per-day rates include healthy snacks and lunch except for "Half Day".

Other Services and Fees

Payment Source: Private ____, VA____, Medicaid ____, Alz _____, Seniors _____, ILG ____
Application fee $75, TB test $28 per test, Shower $30, Limo tours $20.

Transportation one way $10 minimum, $1/mile over 10 miles.

- Some individuals may have multiple conditions or specific needs which may require frequent staff intervention and supervision beyond Level II. All rates will depend on the assessment performed by MTL management.
- Harmful or abusive individuals will be referred to a more appropriate facility.
- Those who attend at least three times per week are more likely to enjoy their participation at MTL.
- Some individuals who meet low-income and other criteria may qualify for financial assistance.
- MTL is an approved Medicaid and VA provider.

Responsible party understands and agrees to abide by all of the More to Life Policies as outlined above and on the included pages.

_____ _____
Responsible party (Print) Client (if applicable)

_____ _____ _____ _____
Responsible Party (sign) Date MTL Director Date

Client Rights

1. You have the right to be fully informed of all your rights and responsibilities as a client of the program.

2. You have the right to appropriate and professional care relating to your needs.

3. You have the right to be fully informed in advance about the care to be provided by the program.

4. You have the right to be fully informed in advance of any changes in the care that you may be receiving and to give informed consent to the provision of the amended care.

5. You have the right to participate in determining the care that you will receive and in altering the nature of the care as your need change.

6. You have the right to voice grievances with respect to care that is provided and to expect that there will be no reprisal for the grievance expressed.

7. You have the right to expect that the information you share with the agency will be respected and held in strict confidence, to be shared only with your written consent and as it relates to the obtaining of other needed community services.

8. You have the right to expect the preservation of your privacy and respect for your property.

9. You have the right to receive a timely response to your request for service.

10. You shall be admitted for service only if the agency has the ability to provide safe and professional care at the level of intensity needed.

11. You have the right to be informed or agency policies, charges, and costs for services.

12. If you are denied service solely on your inability to pay, you have the right to be referred elsewhere.

13. You have the right to honest, accurate information regarding the industry, agency and of the program in particular.

14. You have the right to be fully informed about other services provided by this agency.

Initial:_____

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I hereby authorize More to Life Adult Day Health Center to disclose from the health records of:

Name:_____
last first mi

DOB:_____ SS#_____ Telephone_____

Address:_____
street city state zip

Covering the periods of healthcare (Date(s) of service): From (date): _____to (date):_____

For the purpose :_____
(if requested by the patient, simply state "at the request of the individual")

To disclose to (receiver of information):_____

The following information may be released: (please indicate the types of records that may be released, i.e. clinical summaries, laboratory reports, nurses' notes, or all medical records):

_____

Check and initial all that are applicable:

I understand that this will include information relating to:

_____[ ] Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
_____[ ] Behavioral health services and/or psychiatric care
_____[ ] Treatment of alcohol and/or drug abuse
_____[ ] Physical examination reports
_____[ ] TB test results

I give (*provider of information*)_____
permission to release the information I have selected on this form to the individual(s) or provider(s) I have named for the purposes I have checked.

_____ _____ _____
Responsible party signature relationship to client date signed

Informed Consent: Test for Tuberculosis

Name:_____

Age:_____ Birth date:_____ Phone:_____

Address:_____
(Number and Street) (City) (State) (Zip Code)

To determine if the tuberculosis organism has ever entered your body, a drop of solution is placed under the skin on the forearm. The area is read **48 to 72 hours (2-3 Days) later** by a nurse. Don't miss this appointment or the test will need to be repeated. The second test is to be done **1 to 3 weeks after** the first test is read. Avoid scratching or irritating the area where the test was placed.

When reading the TB test, the nurse measures if there is an area of swelling or hardness, and checks for any history that could cause tuberculosis infection. Depending on your history, your skin test is positive if swelling is more than 5mm across. If your skin test is positive a chest x-ray will be required. Only with a clear chest x-ray report and a completed screening form can this person be admitted to MTL.

If you answer yes to any of the following questions, please explain:	yes	no
Have you ever had a skin test for tuberculosis? When_____	[ ]	[ ]
Was it positive (swollen)? Describe_____	[ ]	[ ]
Have you ever been treated for tuberculosis? When_____	[ ]	[ ]
Have you had a live vaccine in the last 6 weeks (oral polio, influenza, measles, yellow fever, chicken pox, etc.)? When_____	[ ]	[ ]
Have you ever received immunizations for tuberculosis (BCG)? When_____	[ ]	[ ]
Are you on medication that specifically lowers your resistance to infection (steroids, treatment for cancer) When/What?_____	[ ]	[ ]
Do you have any known immune system deficiencies? What?_____	[ ]	[ ]

Your Doctor can do this or a clinic or have our nurse do it at More to Life for $28 where we place the test on a Monday at 3:00 and read the result on Thursday before 3:00.

I have read and understand the above information and give my consent for this test.

Family Care Giver Signature: _____Date:_____

Nurse completes section below							
	PLACEMENT				READING		
	Lot#	Test date/time	Site	Nurse	Reaction	Read Date/time	Nurse
PPD#1					mm		
PPD#2					mm		