



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.

Instructions.....	2
Application for Enrollment.....	3
Medical Information Social History.....	4
Social History.....	5
Policies and Client Agreement.....	7-11
Level of Care and Fee Schedule.....	12
Client Rights.....	13

Other Documents to be completed

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

TB Test Consent form

Updated 10/30/17

Instructions

1. Please feel free to ask for assistance. Call 775-358-1988
2. After completing the forms, return the entire **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 TB results to More to Life and join the program.
8. **TB2**: 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
JeffDold@gmail.com
www.AdultDaycareReno.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 T H 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: X _____ 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: X _____

Date: _____

Page intentionally left blank

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 executor, 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.

Initial:

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, social media, 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
	<u>Full Day</u>	<u>Half Day +</u>	<u>Half Day</u>	<u>Saturdays</u>
<u>Level 1:</u>	\$ 64	\$ 49	\$ 39	\$ 64
<u>Level 2:</u>	\$ 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.

_____	X _____	_____
Responsible party (Print)	Client (sign if applicable)	Date
X _____	_____	X _____
Responsible Party (sign)	Date	MTL Director (sign) 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 of 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: