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. We strive to meet the needs of the frail elderly and adults with disabilities 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 for the caregiver.

Updated 9/20/22

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. Have primary care Doctor complete a **Client Medical Report** within 6 months prior to enrollment.

5. Complete the **TB Test** (for tuberculosis) called QuantiFERON blood test.

6. Bring a copy of the receipt indicating that the TB test was started and join the program.

7. Bring a copy of the results to More to Life.

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-11
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 full name (one to receive care at More to Life)_____
Preferred name:_____ date:_____
How did you learn about More to Life?_____

Please **circle five** program features at 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	position of responsibility	patio gardening
wellness monitoring	secure facility	arts and crafts
financial aid	caregiver support	book club
Saturdays/holidays	communication board	fall reduction exercise
manicure, pedicure	med reminders	haircut, color, set
limo tours	comedy hour	musical performances
walking club	men's group	Spanish club
holiday celebrations	Bingo	balloon sports

Responsible party (person caring for care recipient):

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.
Billing address (if different than above): _____

Client Info (person receiving care at More to Life):

Physical address:_____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:

Name	Relationship	City/State	Phone number

Desired client attendance schedule: M T W TH F S Start time _____ Depart time_____
Transportation to and from center:
Family vehicle _____ RTC ACCESS Bus_____ More to Life Limo _____

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 taken 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 declining conditions in recent months relative to the following:

Repetitive questioning	Y_____ N_____
Searching	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_____
Can client read vocally ?____ books _____ kinds of books _____ magazines_____

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:_____

Page intentionally left blank

More to Life Policies and Client Agreement

Initial:_____ **PROGRAM POLICY** Client name:_____

- 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 proper 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.
- 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 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 self-administered as reminded by staff according to written physician's orders.
- All medications must be provided in the fully labeled containers in which they were dispensed.
- Clients are not permitted to possess medications while in the facility.
- 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 name:_____

- 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.
- Payment method: Check ___ Cash ___ Card___

OPTIONAL RECURRING CREDIT CARD PAYMENT AUTHORIZATION

I, _____ authorize More to Life Adult Day Care Center to carry out regularly scheduled charges to my credit card for services rendered.
No additional prior-notification will be required prior to charging the provided credit card.
A monthly billing statement will be provided to show what charges have been incurred and charged.
I agree to notify More to Life, in writing, of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions so long as the transactions correspond to the terms indicated in this authorization form.

Billing address for card _____
Card type:_____ Card number: _____Exp. date: _____
CSN (code):_____Name (as it appears on the card) _____
Card holder Signature: _____ Date:_____

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 copies 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

	Open 7 to 4 Monday - Friday		(no lunch)	
	over 5 hours	**under 5 hours**	**under 4 hours**	**9:00 – 4:00**
	Full Day	**Half Day +**	**Half Day**	**Saturdays**
Level 1:	$ 95	$ 75	$ 65	$ 95
Level 2:	$ 115	$ 95	$ 85	$ 115

These per-day rates include healthy snacks and lunch except no lunch for "Half Day".

Payment Source: Private ____, VA____, Alz _____, Seniors _____, ILG _____
Application fee $95, Shower $30, Limo tours $30.
Transportation one way $20 minimum, $2/mile over 10 miles.

- No minimum attendance is required but attending at least three days a week is highly encouraged.
- MTL is an approved **VA PROVIDER.** Veterans receive free attendance and free transportation with prior authorization from the VA.
- Those who attend at least three times per week are more likely to enjoy their participation.
- Participants remaining after closing time will be charged $1/minute unless prior arrangements have been made.
- Harmful or contagious individuals will be referred to a more appropriate facility.
- Please refer to the separate list of "Programs for Financial Assistance" for those who qualify.

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:_____

CLIENT REGISTRATION FORM

LEGAL NAME (First/Last): _____

NICKNAME: _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____/____/____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: (If Different) _____

☐ No Current Address/Residence

EMERGENCY CONTACT INFORMATION:

NAME 1 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

NAME 2 (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

ETHNICITY

☐ HISPANIC OR LATINO
☐ NON-HISPANIC OR LATINO

RACE

☐ WHITE, CAUCASIAN ☐ HISPANIC
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ ASIAN ☐ BLACK / AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ OTHER _____

If you do not speak English, what is your primary language? _____

YOUR INCOME IS:

(The Service Provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)

Please provide an answer on both lines:

☐ BELOW POVERTY **OR** ☐ ABOVE POVERTY

☐ BELOW 300% SSI **OR** ☐ ABOVE 300% SSI

DO YOU:

1. LIVE ALONE? ☐ Yes ☐ No
2. HAVE A DISABILITY? ☐ Yes ☐ No
3. CONSIDER YOURSELF FRAIL? ☐ Yes ☐ No

ARE YOU:

1. UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)? ☐ Yes ☐ No
2. A VETERAN / SERVED IN ARMED FORCES? ☐ Yes ☐ No
3. ON STATE MEDICAID? ☐ Yes ☐ No
4. A CAREGIVER? ☐ Yes ☐ No

IF YES, for whom do you provide care?

☐ Spouse ☐ Child, Age 0-18 ☐ Adult Child, 18+
☐ Parent ☐ Family Member ☐ Other _____

☐ I was provided the *Notice of Privacy Practices*

_____ _____
Client Signature *(Initial or Revised Registration)* Date

_____ _____
Client Signature – 2nd year Date
(I certify that my information has not changed.)

FOR OFFICE USE ONLY

Services Registered For: ***New to This Service?***

☐ _____ ☐ Y ☐ N
☐ _____ ☐ Y ☐ N

Nutrition Risk Assessment Score: _____
Client ID: _____
Site/Notes: _____

Your Name (Please Print) _____ Date _____

DETERMINE YOUR NUTRITIONAL HEALTH

Circle each that applies to your nutritional habits.	YES
1. I have an illness or condition that made me change the kind and/or amount of food I eat.	2 points
2. I eat fewer than 2 meals per day.	3 points
3. I eat few fruits or vegetables, or milk products.	2 points
4. I have 3 or more drinks of beer, liquor or wine almost every day.	2 points
5. I have tooth or mouth problems that make it hard for me to eat.	2 points
6. I don't always have enough money to buy the food I need.	4 points
7. I eat alone most of the time.	1 point
8. I take 3 or more different prescribed or over-the-counter drugs a day.	1 point
9. Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 points
10. I am not always physically able to shop, cook and/or feed myself.	2 points
Total Your Nutritional Score	

If your score is . . .

0—2 Good! Recheck your nutritional score in 6 months.

If it's . . .

3—5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Refer to the attached handout for helpful tips. Recheck your nutritional score in 3 months.

6 or more You are at high nutritional risk. Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
2018 FEDERAL POVERTY GUIDELINES

Size of family unit	Federal Poverty Guidelines *48 Contiguous States and D.C.*	
	Annual Income	Monthly Income
1	$ 12,140	$1,011.67
2	$ 16,460	$1,371.67
3	$ 20,780	$1,731.67
4	$ 25,100	$2,091.67

Social Security Administration:

Supplemental Security Income (SSI) – 300% 1 Person Household		$2,250.00