Adult Medical Day Care of Overlea, Inc.

Senior Center Plus

ADMISSIONS AGREEMENT

Name:____ **Phone:**______________________

Address:_______________________________________ **SSN:**_________________________

PURPOSE

- The purpose of Adult Medical Day Care of Overlea is to provide a safe, structured environment and a flexible therapeutic program of services and activities, with individual plans of care, designed to permit participants to remain in their homes and communities, living as independently as possible, with dignity and a renewed sense of purpose and hope.

- Adult Medical Day Care of Overlea provides these services to participants without regard to race, color, country of origin, religion, sex, marital status, and physical or mental handicap.

SERVICES AVAILABLE

- Services covered by the daily fee include a program of diverse educational, social and recreational experiences, assistance as needed with activities of daily living, nursing services, social services, consultation with participant's physician, nutritious meals (breakfast, lunch and a snack) and transportation to and from the center.

- A monthly activity calendar and menu are sent home via the buses each month.

GOALS

- Upon admission, the nurse, social worker, and activity director will obtain medical, social, nutritional, and recreational information from you, family members, and medical records. This information will be used to create a plan of care that will address your unique needs and goals. This care plan will be reviewed and updated periodically throughout your stay. You and/or your representative shall have access to this plan of care and be encouraged to participate in all care plan conferences. If it is determined that this program is not meeting your needs, the center staff will assist in developing a discharge plan.

DISCHARGE

- If and/or when your needs no longer require or cannot be met by Adult Medical Day Care of Overlea, a discharge plan will be developed by the social worker, who will also assist you in obtaining the resources you need to implement the plan.

- The center may initiate discharge for the following reasons:
  - Continual disruptive behavior that cannot be changed or controlled after medical and staff interventions.
  - Participants and/or families who are unable or unwilling to cooperate with established Center policies.
  - Persons whose needs require repeated 1:1 intervention.
- Notice will be given 30 days prior to a center initiated discharge, except in the following cases:
  - The health or safety of the participant or other individuals in the center would be endangered by the continued presence of the individual o The participant has urgent medical needs o There is an emergency requiring less than 30 days notice.
- If you choose to withdraw from Adult Medical Day Care of Overlea, we require a minimum of a two week notice unless there are mitigating health concerns.

LEAVE OF ABSENCE

- If you are out of the center in excess of 30 days, you may be discharged. Ability to return will be determined after a re-evaluation by the center nurse and receipt of an updated medical application from your physician.

MEDICAL TREATMENT

- Basic medical treatment is available by nursing staff at the center. In the event of a sudden illness or injury, it is understood that you give permission to be transported to a hospital by ambulance. Any cost incurred will be at your expense. Center staff will make every effort possible to notify your family or responsible party listed as emergency contact as well as your personal physician.

- We must have a working phone number on file to reach your emergency contacts in the event of an emergency. Failure to keep changes in phone number and address up to date may result in discharge from the program.

- The facility shall not be liable for any injuries suffered by a client while under the facility's care, except when caused by negligence of facility employees. If a client leaves or is removed from the facility for any reason, its agents and employees are released and discharged by the client from all liability for injury suffered by the client while away from the facility.

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HOURS OF OPERATION

- The Center is open Monday through Friday from 7:30 am to 4:00 pm. Medical Day Care Hours are from 8:30-3:00, with extended hours from 7:30-8:30AM and 3:00-4:00PM.
- The center is closed on New Years Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day.

CLOSING OF THE CENTER

- In the event of a delayed opening or closure due to inclement weather, Center staff will make every effort to call. The answering machine at the facility will also be updated with information regarding delays or closures.
- In the event of early closing due to inclement weather, we will contact the name provided as the emergency contact. A responsible party must be available in the event of the center closing early.

ATTENDANCE

- You may attend a minimum of two (2) days or up to a maximum of five (5) days per week.
- The days that you plan to attend the Center are:

☐ Monday ☐ Tuesday ☐Wednesday ☐ Thursday ☐ Friday

- You are expected to attend the center based on the schedule that you have agreed to.
- For same day absences, please contact the center as soon as you are aware that you will be absent, The center has a 24-hour voicemail service. The center opens at 7:30 am each day if you prefer to speak with someone.
- Please communicate all information regarding absences with the Director.

ADDITIONAL DAYS:

- If you wish to add a day to your schedule, please contact the Director. We will do our best to accommodate your request, however we cannot guarantee a space will be available. The following month's bill will reflect the added day.

Transportation Arrangements:

☐ I Choose to use the Center transportation. ☐ AM ☐ PM ☐ Both

☐ I will provide my own transportation. (see hours of operation)

If choosing to use Center transportation, refer to Transportation agreement for an explanation of our transportation services and policies.

Billing

- The Cost of attending the Senior Center Plus Program is $68/day.
- Client and/or Representative agree to pay the Facility the sum of $____________ (dollars) per day of services, for an agreed number of days per month, which is payable monthly. The Facility may change the daily rate only upon thirty (30) days advance written notice to the Client and/or Representative.
- After the first month, bills for days attended will be sent on the first day of each month and are **payable upon receipt**, no later than the 10th of the month. If unable to keep this commitment due to unusual circumstances, please call to arrange a meeting with the Director.
- All Bills not paid by the 10th of the month will incur a 1% late charge, UNLESS arrangements have been made with the business Office.
- Payment can be made by check or money order made payable to Adult Medical Day Care of Overlea, Inc. We do not accept credit card payments at this time. Payments should be mailed to our Business Office at 6401 Dogwood Road, Ste 108, Baltimore, MD 21207.
- In the event of failure or refusal to pay any amounts charged under the terms of this agreement, client and/or representative agree to pay attorney's fees in the amount of (25%) of the outstanding balance due or $250, whichever is greater, in addition to all charges, expenses, and court costs attributable to collection and/or litigation including but not limited to filing fees, private process fees and related costs.

Third Party Payment

- Client and/or representative accept full financial responsibility for and agree to pay the full amount charged by the facility in the event that any third party payer shall deny coverage of or responsibility for client's claim or any party payer shall deny coverage of or responsibility for client's claim or any part thereof. For the purposes of this paragraph, the phrase "third party" shall include the US Department of Health and Human Services, Social Security Administration, State Welfare Agencies, Insurance Companies, and any authorized official or unofficial payer. With respect to Medicaid, denial of coverage shall mean the disqualification of the client as beneficiary under the program. Client and or representative agree to observe, submit to, and obey all current and future rules and regulations established in connection with the operation and maintenance of the facility.

- Client and/or representative hereby certify that the information given to them to enable the facility to apply for payment under Title XVII and XIX of the Social Security Act is correct; further that the facility is hereby authorized and directed to release information concerning Client to other medical facilities, insurance companies, Federal and State Agencies, and regulatory bodies, in connection with any illness or treatment to be rendered, to the extent necessary to obtain payment and otherwise comply with applicable laws and regulations

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FINANCIAL AGREEMENT

- Client and or representative agree to reimburse the facility for loss or damage suffered by the facility as a result of negligence on the part of the client. Client and/or Representative agree to indemnify and hold harmless Facility for any injury to the person or property of others resulting from the negligence of the client.

- This confession of judgment clause is included in this financial agreement and is executed on this date herewith. If payment of any amount due under this agreement, or any part thereof, shall not be made when due, the undersigned hereby authorize and empower any attorney of any Court of Record within the United States to appear for the undersigned, either jointly or severally, in favor of the Facility for the amount due hereunder with interest and cost of sit and attorney fees of twenty five percent (25%) of the amount due or $250, whichever is greater.

- If this agreement is referred to any attorney for collection and payment is obtained without entry of judgment, then the undersigned shall pay the Facility's attorney fees in the amount foresaid. If there are more than one undersigned, their liability shall be joint and several, and any use of the singular therein may also refer to the plural and vice versa and the use of any gender shall be applicable to all genders.

I or we have read, or been read, and fully understand the Admissions Criteria and agree to the conditions set forth therein.

I or we hereby agree to be jointly and severally liable for compliance with all terms and conditions of the Admission Agreement.

l, or we, agree to be responsible and to pay for, when due, all sums due and owing, to Adult Medical Day Care of Overlea, Inc. for the above named client in accordance with all terms and conditions which I or we agree to abide by.

____ ____________________

Signature of Participant or Representative **Date**

____ ____________________

Signature of Center Representative **Date**

Adult Medical Day Care of Overlea, Inc.

Application Form / Admission Record

Client's Name:_______________________________________ **Record #**___________________________

Address: ____

Telephone #______________________________ **Social Security:**________________________

Date of Birth:_______________ **Sex: Female** ☐ **Male** ☐ **Race**________________________

Marital Status: **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐

Religion:____________________________ **Past Occupation:**___________________________

Client's Current Living Situation:

☐ **Alone** ☐ **With Spouse**

☐ **Other Family Member (Relationship)**__________________________ _________________________

☐ **Group Home Name:**____ ______________________

☐ **Assisted Living Community Name:**____

☐ **Other (Specify):**____

Name Of Primary Caregiver:________________________________ **Relationship:**______________________

Address:____**Telephone #**_______________

Email address:_____________________________ **Alt Phone #**_________________________

2nd contact person: ________________________ **Relationship:**_________________________ **Address:**_______

_____________________________________ **Telephone #**__________________________

Case Manager:___________________________ **Telephone #**__________________________

Medical Assistance # (If applicable):____

Medicare # (if applicable):_____________________ _________________________________

Primary Physician:________________________ **Telephone #**__________________________

Address:____ **Fax#**______________________ **Other Medical**

Specialist:______________________________________ **Telephone #**_____________________

Address:____ **Fax#**________________________

Additional Comments / Information:

____

Please Check Off Intended Days Of Attendance:

Monday ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐

Starting/Admission Date________________________ **Method of Pay:**____________________

Adult Medical Day Care of Overlea, Inc.

FALLS, FIELD TRIPS AND PHOTO RELEASE

The overall goal of Adult Medical Day Care of Overlea is to enhance the quality of life and promote the maximum level of independence for all participants who attend.

______ I Understand that one of the Center goals is to encourage mobility for each person; therefore, there is always a potential for falls. Although the Center will do everything feasible to ensure the safety of everyone, it is not possible to provide continuous one-on-one assistance for each participant. Therefore, I clearly understand that accidental falls can occur but feel the benefits of attending outweigh the risks of falling.

______ That included in the Center's program of scheduled activities are occasional field trips. I understand the Center will do everything feasible to ensure safety, and that an accidental fall or injury could occur but feel that the benefit of being included in a planned trip outweighs the risk of injury.

Adult Medical Day Care of Overlea requires that a photograph of each participant be taken for identification purposes. This photograph will be kept in the participant's medical record and the emergency binder.

Additionally, Center staff often takes photographs of participants during activities. These photos may be used in activities (i.e. scrap booking, framing, etc.) or hung in the center.

Photos may also be used for marketing purposes, which may include, but are not limited to use in flyers, brochures, or the Center website.

Please initial as appropriate below:

______ I understand that a photograph will be taken of me for identification purposes.

______ I give permission ________ I DO NOT give permission
For photographs of me to be taken for use at the center.

______ I give permission ________ I DO NOT give permission
For photographs of me to be used in marketing materials, which may include but are not limited to flyers, brochures, and/or the website.

Name of Participant

Signature of Family Member / Responsible Person **Date**

Center Representative **Date**

Adult Medical Day Care of Overlea, Inc.

Transportation Information

Participant's Name: ______________________________ Date: ___________ Race: ____________

Mailing Address: ____

Street Address: ____

Phone Number: ____

Caregiver's Name: ______________________________ Relationship: _______________________

Address: ____

Phone: ____

Directions to Home: ____

____

____

Check all that apply:

☐ Ambulatory ☐ Use wheelchair for transport ☐ Assistance Required

☐ Cane ☐ Walker ☐ Confused Sometimes

☐ Wheelchair Ramp ☐ Visually Impaired ☐ Dementia/Alzheimer's

☐ Hearing Impaired

Medical Condition Comments: ____

____

____

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Is there Anyone home when the participant arrives home? ☐ Yes ☐ No

Can the participant remain home alone/unattended? ☐ Yes ☐ No

I do / DO NOT give permission for: ______________________________ to remain home alone.

Signature of Participant / Caregiver: ___________________________ Date: _____________

Internal Use Only

Scheduled attendance days ______________ Wheelchair transport? ______________

Driver Assigned _______________________ Date Assigned ____________________

Date Completed ______________________

Pickup Time _________________________ Drop off time ____________________

Adult Medical Day Care of Overlea, Inc is committed to ensuring that no person is excluded from participation in, or denied the benefits of its transportation services on the basis of race, color or national origin, as protected by Title VI in the Federal Transit Administration (FTA) Circular 4702.1B. For additional information on Adult Medical Day Care of Overlea, Inc's nondiscrimination policies and procedures, or to file a complaint, please contact the Program Director, Adult Medical Day Care of Overlea, Inc, 5800 Belair Rd, Baltimore, MD 21206.