Clarksville - Montgomery County Ajax Turner Senior Citizens Center
The Senior Circle of Friends Adult Day Center
License No: V9-2706-A-63
953 Clark Street, Clarksville, TN 37040
Phone 931 - 648 - 1345 0r 648 - 9727 Fax 931 - 552 – 6106
E-mail: ctr7528@ajaxturner50plus.org or adc@ajaxturner50plus.org
Web site: www.ajaxturner50plus.org

To: Caregivers of Potential Adult Day Center Clients

Please read the following five (5) pages explaining our adult day center program, policies, regulations, and criteria for enrollment.

Senior Circle of Friends ADC's services and programs are aimed at elderly adults who are frail, individuals who cannot be left alone while recovering from stroke, minor injury or surgery, those with physical or mental challenges, showing signs of Alzheimer's or just in need of some supervision or moderate assistance. Those with severe behavioral or care management challenges or with advanced Alzheimer's disease would not benefit from our services.

It is the policy of the CMC Ajax Turner Senior Citizens Center not to discriminate based on income, race, color, National origin, sex, sexual orientation, or disability in its hiring and employment practices, or in admission to access to or operation of its programs, services, and activities.
If you have questions concerning enrollment eligibility, please contact our staff. A trial enrollment might be considered.

Index

Pg. 2. Mission Statement, Purpose /Goals, Services provided
Pg. 3. Adult Day Center Policies and Procedures
Pg 4. Regulations, Criteria for participants of Adult Day Center
Pg 5 & 6. Policies and Admissions Agreement
Pg 7 & 8. Participants Information
Pg. 9. Activities of Daily living
Pg. 10. Work sheet for Individual Care Plan
Pg. 11. Release form
Pg. 12. Contract for Attendance
Pg. 13. Waiver of Liability
Pg. 14, 15 & 16. Medical forms
Pg. 17. Application for sliding scale.

Mission Statement

Provide a community-based, socially structured group program to meet the needs of functionally impaired adults in a protective setting.

Purpose/Goals

1. Provide a safe, stimulating environment for individuals whose main caregiver must work outside the home.
2. Allow the individual to remain in the home environment in their community, maintain current level of functioning, individual self-worth and dignity for as long as possible.
3. Provide support, education, and day-time congregate respite for full-time caregivers.

Services Provided

This Adult Day Center provides planned, structure, physical, and mentally stimulating, activities, health screening, nutritional snacks, and hot meals in a social setting. Daily programming schedules, activities, and menus are available in advance monthly. The ADC program will be person-centered with Individual Care Plans encouraging family and community involvement.

Caregivers may schedule onsite specialist visits for their loved one while the participant is attending day center. Examples: hospice, physical or occupational therapy

Participants have opportunity to attend weekly nondenominational religious service. Family and friends may share lunch with participant on site or participant may be signed out by responsible party to attend lunch or any other community function or event of choice.

Caregiver Support: Support groups will meet on site or at the public library and educational information will be provided.

Transportation: Families must arrange for all participants' transportation.

Cost of Services: Income based.

Location of Services: Services are provided only at 953 Clark Street.

Hours of Services: 7:30 a.m. to 5:00 p.m. Monday through Friday. If extended hours become available (extra fees will apply). Participants may choose to attend for a few hours or whole days. Holiday closings will be the same as for other activities of the Ajax Turner Senior Citizens' Center. Inclement weather policy: The ADC will be closed when Montgomery County schools are closed due to weather conditions. See contact information on cover page of enrollment packet.

Ancillary Services: Shower, washer, and dryer on site. If extended hours of operation become available on evenings and Saturdays (extra fees will apply). Revised 2/23/15 rev 3/15/17.

Adult Day Center -Policies and Procedures

Information, Referrals, Health Education, and Consultation: Provided to families, potential participants, and the community at large. Annual surveys provided to assure the quality of care provided.

Meaningful Activities: Opportunities to engage in group discussions, music, singing, exercise, entertainment, arts and crafts, hobbies, picnics, games, social interaction to include intergenerational and pet therapy. There are opportunities to participate in programs and activities of the senior center when a one-on-one trained staff or volunteer is available to assist.

Health-related Medical Support Services: Medication reminders, daily blood pressure checks, health screenings and clinics. This facility does not provide any type of medical treatment. A first aid/sick room is available to isolate a participant who becomes ill during their scheduled time at the Day Center or until responsible guardian arrives. EMS will be called if necessary.

If it is revealed to ADC staff that there are conditions or circumstances that place the individual or household of the individual to be in imminent danger appropriate officials will be notified.

Participants should be able to operate, maintain and administer life saving devices /medications. Example: insulin for diabetics or oxygen for oxygen-dependent participants. If caregiver and participant prefer a trained skilled professional, one may visit and assist with proper maintenance or administration of the device or medication at the caregivers' expense.

Caregiver may schedule any specialist onsite visit to benefit good health of the participant.

Facility: Non-medical and un-gated but built to American with Disabilities Act (ADA) standards. Designed with home-style comforts and surroundings, including a kitchen, TV and rest area with recliners and lift chairs.

1. **Staff**: Well, trained, caring staff with an initial orientation and ongoing education to disabled elder care, The ADA of 1990, and all required training by DHS, GNRC, CHOICES PROGRAM to include but is not limited to; critical incident reports, detection and reporting of elder abuse, Title VI, CPR, documentation, disability awareness, cultural competency, disability etiquette, overcoming communication barriers (sign language, non-verbal, and assisted devices), ethics and confidentiality, HIPPA, HITECH, person centered services and supports, dealing with behavioral health, dementia, and Alzheimer's.

Regulations

Adult Day Center Services Standards have been issued and regulations have been approved by the Tennessee Department of Human Services, Division of Community and Field Services. A copy of these rules and regulations is on file in the center's office. Additional information developed by the National Adult Day Services Association (NADSA) of the National Council on the Aging is also used to plan programs and activities. Records maintained for 10 years.

Criteria for participants of Adult Day Center

1. Participants must have an initial screening conducted by ADC staff. Screening may be done during a trial enrollment. The screening includes (but not limited to) observation of potential enrollee without family presence in the ADC setting. Family members or guardian/trustee must complete In-take forms and schedule attendance.
2. Participants must be able to understand and follow simple directions and sit for group activities.
3. Participants must not present a significant threat to themselves or others.
4. Participant should be able to communicate needs and thoughts for sufficient benefit.
5. Participants must be either continent of bowel and bladder or be able to attend to bathroom needs independently of staff supervision. Reminders will be given if needed.
6. Participants who require medication during the day must bring medication in a duplicate prescription bottle with dosages and schedule indicated. If a medication is required at multiple times daily while in attendance each dosage must be in a separate duplicate prescription bottle with dosage and schedule indicated. The bottle should contain only the exact dosage needed for the specific time for that day. Staff does not administer medication but will store it in a locked area and remind participant to take it at the designated time. At indicated dosage time reminders will be given and two staff members will observe, and sign for verification.
7. Participant must be able to operate maintain and /or administer any life saving devices /medication. Example: insulin for diabetics or oxygen for oxygen-dependent participants.
8. Participants must not require nursing care or attend with a fever or serious illness.
9. Family members /responsible guardian must provide or arrange all transportation for participants. When using public transit pickup must be scheduled no later than 4 p.m.

Senior Circle of Friends ADC

Policies and Admissions Agreement

I have read, understand, and agree to the following:

2. Hours to be spent at the center will be based upon the participant's ability level and caregiver need. Hours will be approved by the ADC's manager and will be reviewed as the participant's ability level changes.

3. Enrollment is by appointment only. There is a non-refundable $35.00 enrollment fee. No prospective participant can be left in the Adult Day Center until entire enrollment package has been completed and approved by the Manager or the Director. As previously stated, participant must have had initial screening conducted by ADC staff.

4. Days to be spent at the center will be based upon participant's ability and caregiver need. A minimum of three days per week is recommended for the participant to remain adjusted to the program and receive maximum benefit from activities.

5. Personal care charges are in addition to regular daily fees.

6. Center hours Monday - Friday 7:30 a.m. - 5:00 p.m. Late pick up charges is $5.00 for each five minutes or portions thereof. See cover page for contact information.

7. The adult day center must always have two current emergency numbers on files.

8. Transportation to and from the center is provided by the caregiver or designated driver. Caregiver or designated driver must escort the participant into activity room and sign in. Participant may be checked out to attend appointments or events by the designated driver/responsible party. The adult day center must have name(s) of designated driver(s) on file. Transportation via public transit must be scheduled to pick up no later than 4 p.m.

9. Prescription medications must be brought to the center daily in a duplicated prescription bottle containing only the exact dosage indicated. If medication is required multiple times daily while in attendance each dosage must be in a separate duplicate prescription bottle with dosage and schedule indicated. The bottle should contain only the dosage needed for the specific time for that day. Medication will be locked in safe place until designated time when staff will remind the participant and two staff members will observe and sign for verification as medication is taken. Nonprescription medication must be in original container bearing the individual name.

10. Participant must have had physical exam within six months of enrollment. Arrangements for ongoing supervision by a physician must be made once a year thereafter. This is a non-medical facility, in the event of an emergency staff will use Emergency Medical Service to transport participant to Gateway Hospital. All charges for services will be responsibility of the caregiver.

11. Ongoing family involvement is essential. Families are encouraged to visit and attend special events, caregiver classes, and support group meetings.

12. Caregiver will give center 24-hour notice if participant is unable to attend. If participant is ill and cannot attend notification must be made by 8:30 am caregiver will pay full fees for absences without notice. See cover page for contact information.

13. Participants may be suspended or terminated from the program for: behavior which is severe, cannot be managed at the center; communicable diseases; when participant no longer meets criteria; failure of responsible party or caregiver to adhere to center policies; and failure to pays fees prior to service.

14. Participants and Staff with infectious disease or illness such as vomiting, or diarrhea are not allowed to attend center. This is a non-medical facility therefore any participant who becomes ill or injured at the center must be picked up by caregiver or designated driver, within one hour of notification by staff.

15. Participant must be able to operate, maintain and/or administer any life saving devices/medications. Example: insulin for diabetics or oxygen for oxygen-dependent participants.

16. Center closing dates will be published in newsletter. Center may close for inclement weather conditions. If Clarksville Montgomery County Schools are closed for inclement weather this adult day center will be closed.

17. A late fee will be charged for any fees, which are not paid in 30 days.

18. Trained staff or volunteer will accompany participants who wander from site unless redirection is effective. Staff will notify family/responsible party when deemed necessary for the safety of the participant.

19. If participant becomes anxious and ask to leave before scheduled pickup caregiver will be called.

Signature ______________________________ Date ____________________

Witness ______________________________ Date ____________________

A copy of this form will be made for your records.

Adult Day Center Participant Information

Name ______________________________ D O B ___/___/___

Address ____

Age _________ Sex________ Race _________Ethnicity __________________

Primary Caregiver ______________________ Phone___________ Email____________

Power of Attorney ___ Name ________________ Ph # ___________ (provide copy)

Are there current effective Conservatorship documents? ___. If yes provide copy.

Emergency Contact #1 ____

Phones: Home _____________ Work _____________ Cell ____________

Emergency Contact #2 ____

Phones: Home _____________ Work _____________ Cell ___________

Personal Physician _________________________ Phone # ______________

List of prescription and non-prescription drugs the participant currently takes: __

____

Complete form titled: **Current Prescription Medication Form**.

List known allergies of the participant: ___________________________________

____

Is participant on a special diet? ____ If yes explain ______________________

____

Are there any physical or mental disabilities/limitations of the participant? ___________

If so explain: ____

Who is authorized to transport the participant? If needed use the back of this page to list all who may transport participant. Name ____

Phone #: Home _____________________ Work#: _______________________

Special Instructions for Emergency Care: _________________________________

____

Notice: Our office must be notified in writing of any changes in the information provided concerning the care of the participant listed above to assure information and records are current and accurate in case Emergency Medical Services (EMS) is needed.
Use form titled: Client Information Change

Revised 2/23/15 rev.9/15/15 rev. 1/27/16 rev 3/15/17

Personal Information

Name: ______________________________

Information listed below is used in developing care plans. Also, a useful tool for group discussion, currents events and reminisce activities.

Spouse's name, occupation, still living. ___________________________________

____

Children's names and pertinent information: ______________________________

____

____

____

Grandchildren's names and ages: _______________________________________

____

____

____

Solitary Activities: ____

Community activities of interest: ____

Favorites: music, food, flowers, hot and cold drinks, etc: _____________________

____

Family Traditions: ____

____

Sleep habits: ____

____

Any falls in the past year, how severe and how many? ______________________

____

Any repetitive behaviors? ____

Revised 2/23/15

Activities of Daily Living

Participant ____________________________ Caregiver _______________________

Activity	Independent	Needs Help	Unable to do	Comments
Dressing				
Ties Shoes	______	______	______	_______________
Slip on shoes	______	______	______	_______________
Socks	______	______	______	_______________
Buttons	______	______	______	_______________
Zippers	______	______	______	_______________
Underclothes	______	______	______	_______________
Select clothes	______	______	______	_______________
Personal Hygiene				
Bathes self	______	______	______	_______________
Teeth/Dentures	______	______	______	_______________
Brush hair	______	______	______	_______________
Toilet/Bladder	______	______	______	_______________
Eating				
Feeds self	______	______	______	_______________
Prepares foods	______	______	______	_______________
Movement				
In and out of car	______	______	______	_______________
Walk	______	______	______	_______________
Raises from chair	______	______	______	_______________
Cane walker	______	______	______	_______________
Wheelchair	______	______	______	_______________

Communication

Does the participant have any problems with verbal communication? _____________

Hearing aid or hearing problems? ____

Vision problems, glasses, or other? ____

Reads ___________ Type of reading material: _______________________________

Writes ___________

Takes medication when reminded? ________ If no, please explain. ______________

____

Does participant wear dentures? ________Comments__________________________

Follows simple instruction? _____ Comments ________________________________

Ability to use telephone? _____ Comments __________________________________

Other special needs or concerns? _____________

Interest or hobbies: ____

Social History:

Born, raised, brothers, sisters, children, spouse, work, history, church, pets, favorite foods, etc.

____

Does participant wander or try to leave primacies? _____ If yes, explain. ________

____

Your opinion of needs/goals to be met:

____

Work Sheet for Individual Care Plan

Name ______________________ Date ___________ Review Date ___________

Needs/Goals

Social/Emotional ____

Personal Care ____

Therapeutic Activities ____

Physical Activities ____

Participant Goals ____

Family Goals ____

Overall Goal ____

List activities participant is involved in that is helping him/her to reach this goal

____

____

What progress is the participant making towards this goal? ___________________

____

____

What physical or mental conditions do you feel can be enhanced or accommodated by the day center? (This can include things such as exercise to improve mobility)

____

____

What if any changes have been observed regarding the participant's mood, behavior, diet, medication, or other personal circumstances? ______________________________

____

____

List conditions that would prevent individual from coming and going as they chose.

____

____

Other notations: ____

Rev 3/13/15 rev 3/15/17

Release Form

Participant Name: ____

I give permission for the day center staff or designated volunteer to (check all that you agree to):

- ☐ Take a photograph or video tape of my family member
- ☐ Record my family member's voice
- ☐ Use my family member's art work or a reproduction thereof
- ☐ Arrange for publication of my family member's photo for local newspaper(s) and/ or social media (Facebook, website)

Furthermore, I authorize the use and reproduction of these for publicity or education and informational purposes without compensation to my family member or me. All copies and negatives shall constitute the property of the Senior Circle of Friends Adult Day Center.
I understand that only first names will be used for identification purposes. I understand that I will be given advance notice of any photo sessions which will be published in a newspaper. I can refuse individual photo sessions at any time.

Please Note: Failure to agree to any of the items on this release form **will not** affect your family member's eligibility for the program.

Caregiver Signature ______________________________ Date ______________

Witness Signature ______________________________ Date ______________

Revised June 20,2007 rev 1/27/16 rev 3/15/17

Contract for Attendance

The Ajax Turner Senior Adult Day Center Program "The Senior Circle of Friends", has been explained to me and I have been given a copy of the policy statement.

I am enrolling: ____

For: Monday   Tuesday   Wednesday   Thursday   Friday (circle days that apply)

Numbers of hours to attend daily? _____________. I agree to pay weekly or monthly for care at the rate of $ _____________ per day and I understand that this amount is due prior to the service.

The A D C staff agrees to accept this participant for enrollment under the following conditions.

Trial period __ of __ days/ wk. for __ wks. Effective _________ Initials_________

Full time ___ Effective date ______________ Signature ____________________

Part time: ___ day/wk. effective date ______ Signature ____________________

Monday   Tuesday   Wednesday   Thursday   Friday

If emergency medical care becomes necessary, I give permission for any treatment the staff deems necessary. I understand any charges are the responsibility of the participant or caregiver.

Date ___________________   Signature _______________________________

Date ___________________   Witness ________________________________

****

Senior Circle of Friends ADC

I, _________________________________, have read and understand the current Policies and Admissions Agreement, the rules and criteria of the adult center and agree to abide by them.

Date __________________   Signature __________________________

Date __________________   Witness __________________________

Revised June 20,2007 rev 3/15/17

Waiver of Liability

Participant's Name ____

I hereby give permission for my family member to participate in the adult center activities describe below. I will not hold any of the Ajax Turner Senior Center or/and Senior Circle of Friends ADC's staff, volunteers, or board members responsible for any injury to the above-named participant which occurs during any of the activities listed below.

- ❑ Daily activities at the Senior Circle of Friends ADC. To include but not limited to: baking or cooking activities, non-denominational Bible study or devotionals, nature walks, gardening activities.

- ❑ Monitor prescription medications, as prescribed by physician. Medication must be brought to the ADC in a prescription bottle containing only the dosage for that day. Staff will give reminders when medication is to be taken and record time medication was taken.

- □ Monitor nonprescription medications as requested by the caregiver. Caregiver is responsible for bringing the medication to the ADC in its original container.

- □ Monitor Life saving devices/medications as requested by caregiver. Participant must be able to operate, maintain and /or administer any devises /medications.

- □ Manicure given by staff member or volunteer. Performed solely as a bonding activity and as a hygiene service to the participants.

- □ Utilize exercise equipment provided by and within the Clarksville Montgomery County Ajax Turner Senior Citizens Center.
  □Without restrictions □ With restrictions as listed below.

____
____

If there is an item or items, you **Do Not Approve** please indicate below the activity or activities to omit.
____
____

Caregiver __________________________________ Date _______________________

Witness ___________________________________ Date _______________________

Medication Assistance Form

I request staff of the Senior Circle of Friends ADC to assist and monitor medications for __________________________ as ordered by Dr. ____________________. I have read the policies concerning medications and will inform the staff of any changes made in the medication.
Caregiver _______________________________ Date ___________________________

Witness ________________________________ Date ___________________________

Revised 4/4/14 rev.2/23/15 rev 3/15/17

Current Prescription Medication Form

Date: ___________________ Review Date: ____________________

Participant's Name: ____

Allergies: ____

Note: Please, fill out this form or have your pharmacist fill it out. The caregiver is responsible for notifying our office in writing of any change in medication. Each medication must be brought in a prescription bottle/container. No medication will be stored overnight at the center.

Name of Responsible Party ____________________ Signature ________________

Physician ____

Medication	Dosage	Time	Start Date	Purpose	Side Effects

Note: This form will be updated every 6 months or as medications are changed by the participant's physician.

Medical Examination Report

Name ________________________________ Date of Birth __________________

Address ____

Most Recent Date of Medical Exam ____

The above-named individual has applied for enrollment at the Senior Circle of Friends ADC. Your careful examination and written recommendations on this form will help ensure that the applicant is provided appropriate care and services, will encourage safe participation in adult day center activities and will provide a current medical history in case of an emergency. Information reported on this form is considered confidential and will be released only with the applicant's written authorization.

I authorize the release of this information to the Senior Circle of Friends ADC to be placed in the participant record to the above-named person.

Signature _________________________________ Date ______________________

****

List the person's current disease/chronic condition/medical diagnosis __________

____

____

Is the person free of communicable diseases? _______________________________

Allergies of reactions to any medicine ______________________________________

Receiving any medical treatments: If so, explain. ____________________________

____

____

List any special attention required. ____

____

____

Does this person have any psychiatric problems? Yes ____ No ____

If yes, please comment on the nature, severity, and treatment needed: ________

____

____

Does this person suffer from short-term memory loss? Yes ____ No ____

Does this person have dementia? Yes ____ No ____

If yes, list type of dementia: ____

Does this person require constant supervision to make sure he/she doesn't do harm to self, others or property? Yes ____ No ____

Will this person wander off if not closely attended? Yes ____ No ____

Do you recommend any restrictions for medical reasons on physical activities such as walking, exercises, etc.? Yes ____ No ____

If yes, please specify: ____

____

Describe any needed physical therapy: __________________________________

____

Describe any special diet necessary: ____________________________________

____

Any other comments: ____

____

****

I certify that I have reviewed the health history and examined this person and find him/her physically able to participate in the Senior Circle of Friends Adult Day Center Program.

Print Name ______________________________ Date ____________________
Licensed Physician or Physician Assistant

Signature _______________________________ Date ____________________
Licensed Physician or Physician Assistant

Address ____

Telephone ____

Rev 3/15/17

The Senior Circle of Friends Adult Day Center Application for Sliding Scale Fees

Name ______________________ Caregiver Name _______________________
Date _______________________ Completed By _________________________

Long term insurance, with ADC as a benefit? _____If yes bring a copy.
This form is optional. Families who do not complete the form will be charged the full fee.
If you wish to apply for sliding scale fees, complete the following for the participants and his or her household. Please bring documents of the information provided, including bank statements, most recent income tax forms, and copies of social security, pension checks, proof of wages, all income and applicable expenses.
If you choose not to apply for scholarship, please indicate in space here provided.

I _________________choose not to apply for scholarship.
Signature_______________________________ Date _____________

(Head of Household)
Applicant S. S. # _________D/O/B________ Sex___ Race_____ Ethnicity_____
Family size: ______________ # Adults ______________ # Children ___________

Name of Family Member		Week/Monthly	Annual
	Assets		
Participant__________________	Savings / checking	$ _______________	$______________
Spouse____________________	Stocks /bonds	$ _______________	$______________
Income per month			
________________________	Social Security	$_______________	$______________
________________________	Retirement/pension	$_______________	$______________
________________________	Interest	$_______________	$______________
________________________	Other income	$_______________	$ ______________
	TOTAL GROSS INCOME	$_______________	$______________
Household expense			
________________________	Rent / mortgage	$_______________	$______________
________________________	Uncovered medical	$_______________	$______________
________________________	Property taxes/ Insurance	$_______________	$______________

TOTAL EXPENSE $________________ $_______________

I certify that the information contained in this form is accurate to the best of my knowledge.
Caregiver/ responsible party signature ________________________ Date ____________
………………………………………………………………………………………………………

Applicant Income: low income_____ very low income____ very very low income_____

Applicant is Eligible. ________________ Applicant is Ineligible. __________________

Scale: __ $50 ___ $45 ___ $40 ___ $30

Daily fee: ___________ Reviewed by ____________________ Date ______________

Clarksville Montgomery Co. Ajax Turner Senior Center: 935 Clark Street Clarksville, TN. 37040
931 - 648 – 1345
Revised October 3, 2005, August 1, 2007:5/20/09: 7/2014 rev 3/15/17/rev jul12018