

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:

The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.

The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: Senior Concerns Adult Day Program			TELEPHONE: (805) 497-0159
ADDRESS: NUMBER 401 Hodencamp Road,	STREET Thousand Oaks, CA 91360	CITY	
LICENSEE'S NAME: Senior Concerns	FAX: (805-373-6880)	FACILITY LICENSE NUMBER: 56104040	

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:			TELEPHONE:
ADDRESS: NUMBER	STREET	CITY	SOCIAL SECURITY NUMBER:
NEXT OF KIN:		PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:				LENGTH OF TIME UNDER YOUR CARE:	
SECONDARY DIAGNOSIS:					
AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
TUBERCULOSIS EXAMINATION RESULTS <input checked="" type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> NONE				DATE OF LAST TB TEST:	
TYPE OF TB TEST USED:				TREATMENT/MEDICATION: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:		TREATMENT/MEDICATION:	
A) <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, list below:	B) <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, list below:

ALLERGIES		TREATMENT/MEDICATION:	
C) <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, list below:	D) <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, list below:

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.

Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR			COMMENTS:	
	YES (Check One)	NO	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR			COMMENTS:	
	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO			COMMENTS:	
	YES (Check One)	NO	COMMENTS:	
1. Able to care for all personal needs				
2. Can administer and store own medications				
3. Needs constant medical supervision				
4. Currently taking prescribed medications				
5. Bathes self				
6. Dresses self				
7. Feeds self				
8. Cares for his/her own toilet needs				
9. Able to leave facility unassisted				
10. Able to ambulate without assistance				
11. Able to manage own cash resources				

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS

1. Headache
2. Constipation
3. Diarrhea
4. Indigestion
5. Others(*specify condition*)

OVER-THE-COUNTER MEDICATION(S)

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

PHYSICIAN'S NAME AND ADDRESS:

TELEPHONE:

DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE

ADDRESS:

DATE



401 Hodencamp Road Thousand Oaks, California 91360
(805) 497-0189

Participant Information Sheet

Today's Date: _____

Entry Date: _____

Exit Date: _____

Participant Name: _____

Age: _____ Birthdate: ____/____/____

Participant Address: _____

City, State & Zip: _____

Home Phone #: _____

Other Phone #: _____

Primary Caregiver's Name: _____

Relationship to Participant: _____

Primary Caregiver's Address: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Email: _____

ADL Assistance Needed:

Assistance Walking ☐
Walker ☐
Wheelchair ☐
Toileting Assistance ☐
Feeding ☐
Special Diet ☐

Health Conditions:

Diabetes ☐
High Blood Pressure ☐
History of Falling ☐
Poor Vision ☐
Wears Glasses ☐
Medication Allergies: _____
Other Allergies: _____

Poor Hearing ☐
Hearing Aid ☐
Heart Condition ☐
Pacemaker ☐
Osteoporosis ☐

Transportation: T.O. DAR ☐ Agoura DAR ☐ Camarillo CV ☐ Other ☐

Emergency Contacts / Persons Authorized to Pick-up Participant

Name & Relationship to Participant	Address, City, State / Zip	Phone Numbers
		Home: Cell: Work:
Relationship:		
Name & Relationship to Participant	Address, City, State / Zip	Phone Numbers
		Home: Cell: Work:
Relationship:		
Name & Relationship to Participant	Address, City, State / Zip	Phone Numbers
		Home: Cell: Work:
Relationship:		



401 Hodencamp Road Thousand Oaks, California 91360
(805) 497-0189

Person(s) Authorized to Pick-up Participant (optional)

Participant Name: _____ Date: _____

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Email: _____

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Email: _____

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Email: _____

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Email: _____

Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Email: _____



401 Hodencamp Road Thousand Oaks, California 91360
(805) 497-0189

Medication Log

For all medications the participant takes - whether or not they are taken at the Center.
Please advise as to any prescription changes or when a new medication is started or discontinued.

Today's Date: _____

Participant's Name: _____

Mark Box if Taken at Center	Name of Medication Reason for Use	Dosage	Times Taken	Mark if New Medication Initials & Date	Mark if Discontinued Medication Initials & Date
				
				
				
				
				
				
				
				
				

X Caregiver's Signature: _____

Relationship to Participant: _____



Transportation Guidelines

Responsibility to apply and obtain a Dial-A-Ride or Ventura County Transportation Commission ADA Card is that of the Responsible Party. Once Senior Concerns receives a copy of the Card, Senior Concerns will assist in coordination DAR service as a courtesy.

1. **PICK-UP:** Participants must be ready when the Dial-A-Ride (DAR) vehicle arrives. DAR will give you an estimated time of arrival within 15 minutes before or 15 minutes after scheduled pick up time. Daily schedules vary so DAR is not able to specify exactly when the DAR vehicle will arrive.
2. **DROP OFF:** Participants are not allowed to be dropped off home alone unless prior arrangements have been made. If family is not home to receive participant, DAR will return participant back to Senior Concerns if open. If Senior Concerns is closed, dispatcher will attempt to contact family via telephone; if there is no response, participant will be taken to the Police Station for their safety.
3. **DELAYS:** In order to keep on schedule, bus drivers cannot wait more than 5 minutes for any participant to come out of their home if they are not ready.
4. **CANCELLATION or SCHEDULE CHANGES:** Always call Senior Concerns at (805) 497-0189 as soon as possible, if there is a schedule change or cancellation.
 - a. Advance notice is requested for cancellations.
 - b. Emergency cancellations after business hours or on weekends can be made by calling Senior Concerns at (805) 497-0189 and leaving a detailed message on voice mail.
 - c. If the DAR vehicle arrives at the participant's residence and he/she is not ready DAR will not wait.
 - d. If DAR needs to resend a vehicle to pick up a participant later, an additional \$1.00 will be charged for "on-demand service". "On-demand" service from DAR will arrive within 1 hour or less upon receiving the request.
5. **MEDICATION:** **DO NOT send medication with the DAR drivers.** Medication issues must be addressed directly with Program Director and/or Program Leads.
6. **ESCORT:** The DAR vehicle driver cannot leave the bus unattended to escort participants. You must provide escort service, if necessary.
7. **DISCONTINUATION:** DAR and Senior Concerns reserves the right to terminate services to passengers who demonstrate disruptive and/or unsafe behavior or who require assistance beyond that which DAR are able to provide entering or exiting the vehicle. Excessive last minute changes or cancellations may result in discontinuation of service. Participants who arrive home alone consistently may result in discontinuation of service.
8. **COMPLAINTS:** Senior Concerns coordinates DAR as a courtesy. If you have a complaint about the DAR service specifically you may contact DAR directly at 805-375-5467.
9. **BILLING:** Dial A Ride charges are \$3 each way for Thousand Oaks, Newbury Park, Westlake Village and Oak Park, and \$5 each way for Simi Valley and Moorpark. These charges will be billed following the month of services used. Senior Concerns coordinates the rides and provides the advance payment to DAR. **Senior Concerns will add the charge to the monthly statement under transportations coordination.**

Sign below to indicate that you have read and understand the Transportation Guidelines, and agree to reimburse Senior Concerns as billed for any Dial A Ride use.

Participant Name (Printed)

Caregivers Name (Printed) and Relationship to Participant

X

Caregiver's Signature

Date



ADULT DAY PROGRAM ADMISSION CONTRACT

Participant Name: _____ Date: _____

Mission Statement: *The mission of Senior Concerns is to serve seniors and family caregivers by providing quality programs, appropriate resources and educational outreach to Ventura County and western Los Angeles County residents.*

The **Senior Concerns Adult Day Program (SCADP)** is a non-medical, community-based adult day center licensed by the State of California Department of Social Services (CDSS) and Community Care Licensing (CCL) to provide physical, recreational and social activities for adults with cognitive or physical impairments who need supervision and/or assistance with some Activities of Daily Living and respite time for caregivers.

I. Basic Services Include:

- A) Supervised and engaging activities: arts & crafts, brain fitness, cooking classes, discussion groups, music, entertainment, modified exercises, gardening, religious group activities and visiting pets.
- B) Assistance with some Activities of Daily Living (scheduled restroom breaks and guidance).
- C) Nutritious lunch, a morning and an afternoon snack are prepared daily and provided in accordance with and subsidized by the US Department of Agriculture. Most special dietary needs and desires are accommodated.
- F) Daily observation of participant's general health.
- G) Care Management (by appointment).
- H) Information and Referral.
- I) Caregiver Education Programs.

II. Optional Services Available:

- A) Pureed or special needs diet. This includes gluten free. This does not include diabetic diets or vegetarian diets.
- B) One on one feeding assistance.
- C) One on one standby walking assistance.
- D) Daily assistance with Medication Supervision. Participants will be assisted with self-administration of prescription medications, over-the-counter medications, vitamins and supplements in accordance with physician's instructions, unless prohibited by law. Injectable medications are not permitted. Over-the-counter medications, vitamins, supplements and probiotics require a doctor's note on a prescription pad or a note from the physician on his letterhead specifying time and amount to be delivered prior to being dispensed at the Center.
- E) Extra staff supervision due to high needs behaviors and/or wandering risk.
- F) Assistance in the bathroom by one staff. SCADP will provide incontinence products as needed, however caregiver/responsible party is asked to provide personal product supplies if participant has a particular product not available at our center.
- G) Assistance in the bathroom by an additional second staff.

For the optional services listed above the participant will be assessed for these services and the fee schedule adjusted as follows:

- If the participant has a need for 1 or 2 of the items listed in A-G (in any order), the fee schedule will be considered "Low Need".
- If the participant has a need for 2 or 3 of the items listed in A-G (in any order), the fee schedule will be considered "Medium Need".
- If the participant has a need for 4, 5, 6 or 7 of the items listed in A-G (in any order), the fee schedule will be considered "High Need".

The Director of Programs and the Team Lead will assess the participant for these services and provide a Fee Schedule stating the level of need assessed and the corresponding monthly cost.

Additional Services Available:

- A) Morning and Afternoon Extended Care: AM Extended Care is from 7:30 AM to 9:00 AM (Fee: \$15.00 per day) and PM Extended Care is from 3:00 PM to 5:30 PM (Fee: \$20.00 per day).
- B) Saturday Care: Saturday Care is scheduled two Saturdays per month, generally the 2nd and 4th Saturday, however the days may be changed or cancelled based on attendance, staffing or holiday schedule.
- C) Coordination of transportation services for eligible participants with Dial-A-Ride (DAR) (Fee: \$3.00 each way for Thousand Oaks, Newbury Park, Westlake and Oak Park and \$5 each way for Simi Valley and Moorpark). SCADP coordinates transportation services *as a courtesy* for participants with Dial-A-Ride.

III. Eligibility:

Admission to SCADP is made on an individual basis according to a participant's suitability determined by a functional assessment, physician assessment, caregiver's need and program availability. SCADP does not discriminate regarding age, sex or gender, race, religion, color, political affiliation, national origin, disability, marital status, actual or perceived sexual orientation, or ancestry.

We accept participants who are in need of a safe, supportive environment. We are unable to accept those who require skilled nursing care.

- The participant must be able to benefit from regular activities at the day center.
- The participant must be able to rise from a chair and/or wheel chair with minimal assistance.
- The participant must not be so frail as to be in danger of falling or injuring him/herself or staff.
- The participant must not exhibit behaviors which present a threat to themselves or others.

Individuals in need of one-on-one supervision may be asked to provide their own caregiver. Individuals with the following conditions are not eligible to participate in the SCADP: Naso-gastric and naso-duodenal tubes, Active, communicable TB, pressure sores, and conditions that require 24-hour nursing care/monitoring.

Forms required prior to attending program:

A release from the participant's physician, in addition to the completion of a number of other documents listed in Exhibit A are required.

IV. Attendance:

We encourage participant to select a minimum attendance of at least two days per week to receive the full benefit of our program. This helps the participant become familiar with the program and establish relationships with the other participants and staff. **Base program hours are from 9:00 AM to 3:00 PM.** "AM Extended Care" is from 7:30 AM to 9:00 AM and "PM Extended Care" is from 3:00 PM to 5:30 PM

We ask that participants adhere to their scheduled days of attendance. As needs change, we will accommodate according to space and staffing availability. **SCADP requires a two week notice if exiting program.** *Additional days or a change to the schedule of attendance can be requested and are accommodated, as space is available.*

- Changes in participants attendance should be submitted in writing to the Program Lead or Program Director or verbally explained in person or on the phone. Voicemails do not provide confirmation or a change in attendance.
- A participant may make up a scheduled missed day with advance approval, within the month, or an extension may be requested.
- Should a participant leave SCADP temporarily, a one month hold may be placed on the file. After one month time the file will be closed. The participant may return upon reassessment by the Program Director and/or Program Leads, submission of an updated Physicians' Report and an updated signed contract and fee schedule.
- Absences due to serious illness/hospitalization require either a copy of the hospital discharge papers or a Physician's Note clearing the participant to return to SCADP prior to re-entrance into the program to protect the health of all our participants.
- Participant readmission to the program is subject to reassessment and space availability.
- Any request for additional days will be accommodated based upon availability. Additional days will be billed at the agreed upon daily rates based the level of care required.
- If no notice is provided when participant exits the program there will be a charge billed for an additional two weeks.

V. Provisions:

A signed contract is required in advance of admission into SCADP. The Responsible/ Participant Party shall sign a contract committing to the days of attendance and fee for services. If the participant's needs change which necessitates a modification to the Participant's Needs and Service Plan, a new service contract will need to be signed.

For the purposes of this agreement/contract the "Responsible Party" refers to an individual acting as the Family Caregiver, Authorized Representative, Power of Attorney, Guardian, or Conservator that assists the participant in placement or assumes responsibility for the participant's wellbeing and financial obligations.

VI. Modifications to Needs and Services Plans:

A written Needs and Services Plan is updated by SCADP staff as often as necessary, but at least annually to ensure its accuracy and to document significant occurrences that result in changes in the client's physical, mental, psychological and or social functioning. A Physician's Report must be provided when there is a change in functioning, and an Updated List of Medications as often as necessary.

VII. Transportation:

For the protection of the participant, SCADP requires designated persons to be identified for transportation of the participant to and from SCADP. Changes in designated persons or changes in transportation must be communicated with the SCADP staff. The participant will NOT be released to anyone other than a designated person.

Caregivers are encouraged to provide transportation to and from SCADP. If that is not feasible; it is the responsibility of the Participant and Responsible Party to apply for a Dial-a-Ride Card (DAR) or Ventura County Transportation Commission ADA Card. Once we receive a copy of the DAR or ADA Card, SCADP will assist in coordinating DAR services.

As a courtesy SCADP will coordinate DAR services and advance payment to DAR. SCADP will add the charge to your monthly statement under transportation coordination.

It is the responsibility of both the Participant and Responsible Party to adhere to the rules and regulations of the transportation services and reimburse Senior Concerns for all expended expenses.

VIII. Communications:

SCADP encourages families to communicate with the Program Director or Program Leads if there are any changes in a participant's physical condition, mental status, behaviors, medications, living arrangements, home life, social situation, transportation arrangement and/or any other factors which may affect the participant in their ability to participate or benefit from SCADP's program activities.

We realize that circumstances sometimes interfere with your plans and schedule.

Please call the center at (805) 497-0189 if participant is going to arrive early or late or be picked-up early or late.

IX. Absences:

Please call SCADP at least 24 hours in advance if Participant is unable to attend the program on a scheduled day, to inform the staff and arrange for a make-up day within the month. For those times you do not know in advance, please call as soon as possible. Make-up days need to be scheduled as soon as possible.

X. Lost and Found:

It is strongly suggested that families keep all valuables including money, jewelry and heirloom items at home and not send them to SCADP with participants. SCADP cannot guarantee against loss or damage. If the participant would like to bring in an item to SCADP to share in an activity, the item should be carefully packaged and marked. Additionally, a call should be made to the Program Director or Program Lead prior to bringing it in, to arrange for safe keeping.

XI. Consent to be photographed and videotaped:

Photographs and videotaping of the program participants are sometime made by the SCADP staff for the bulletin board, craft projects or media with the intention of raising public awareness of Adult Day Programs. It is the policy of Senior Concerns to keep the participants last names confidential in such instances. Please let us know if you or the participant objects to being photographed or videotaped.

XII. Waiver of Liability:

The Participant and/or Responsible Party agrees to hold Senior Concerns, its Board of Directors, employees, agents, affiliated agencies and volunteers harmless from any and all claims for injury or damage to the participant named herein arising from or in any way connected with the participants participation in the activities of the Senior Concerns Adult Day Program, including the participation in field trips.

XIII. Grievance Procedure:

SCADP is committed to providing you and your loved-one quality care. If there are any program-related concerns with staff, activities, food service, facilities or any other concern, please bring your concern to the attention of the SCADP Program Director, Program Leads or Care Manager. If you have made a good faith effort to resolve your grievance with the above mentioned personnel and you are still not satisfied, the Participant and/or Responsible Party may meet with the President of Senior Concerns to act as the final arbitrator. If you are not satisfied with the Center's resolution you have the right to a fair hearing with Community Care Licensing.

XIV. Exit Criteria/Discharge:

The following conditions/behaviors may prevent a participant from attending SCADP or may necessitate a termination of participation:

- SCADP staff determines that the participant's needs cannot be met.
- Participants who have become so incapacitated as to lose the ability to benefit from our services.
- Participants who exhibit behavior which presents a threat to themselves or others.
- Participants with a communicable disease that could, with or without treatment pose a threat to others.
- Responsible Parties repeated failures to pick-up participant before the center closes.
- Participant's account is 30 days or more past due.

SCADP will provide a 30 day notice and assistance in identifying appropriate alternative care for participants should discharge from the program be warranted. Immediate discharge of an individual is allowed when it is determined that the individual's condition has suddenly changed and participation in SCADP is likely to cause danger to self or others. In this case Community Care Licensing will be notified as well.

XV. Billing:

A non-refundable \$75 enrollment fee is required prior to admission to SCADP. An Adult Day Services Fee Schedule signed by the Responsible Party is also required prior to admission. Participants are billed a monthly fee based on the schedule specified in the signed agreement. **The SCADP invoice is generated by the 5th working day of the following month. Payment is due upon receipt.** SCADP encourages automatic credit card payments for on time payments for our services. A late fee of \$25 will be added if payment is not received by the 1st day of the following month. To ensure ongoing participation in the SCADP, on-time payments are required.

SCADP is unable to offer credits for days missed due to holidays, center closure whether planned or due to natural disaster or communicable health outbreaks or when the local health department or emergency personnel advises closure. Note: Our center is closed for legal holidays and staff development days.

XVI. Scholarships:

If a Participant and/or Responsible Party is unable to pay for SCADP, they may apply for a scholarship, if available. After completing an application and all supporting documentation is provided, application will be submitted to the Scholarship Committee for evaluation. Awards are granted on a case by case basis and subject to funding availability.

Exhibit A

Documents required prior to admission to SCADP

1. Participant Information Sheet
2. Emergency Medical Care Authorization and Release of Liability
3. Prescription Update Form
4. Physician's Report, including Tuberculosis Testing (negative skin test, TB blood test (IGRA's) or chest x-ray)
5. Pre-placement Appraisal Information
6. Client Services Information
7. Intake Questionnaire
8. A signed contract indicating the monthly fee for the Participant and Responsible Party
9. Consent to be Photographed and Videotaped and General Release
10. Personal Rights
11. Non Discrimination Policy Notice
12. Meals Benefit Form

Note: Licensing requires that the Caregiver/Responsible party notify SCADP immediately if there are any changes in the participants' condition and/or medications. Medication and Condition Change Forms are available upon request



ADMISSION CONTRACT

- I agree to pay according to the attached schedule.
- Transportation will be coordinated by SCADP and provided by: _____.
- I understand that I will be billed for my agreed upon days on a monthly basis by the 5th of the next month.
- Additional days, services or DAR trips will be added to the monthly statement.
- Payment is due upon receipt.
- Credit Card Payment is available. If you would like to have automatic payment, please fill out a Credit Card Payment form.
- I understand that I will be billed for 2 weeks if no notice is given upon ending participation in the program.

Responsible Party Signature: X _____ **Date:** _____

1. Please print Name of Participant: _____

2. Please print the Name of the Responsible Party: _____

Please explain relationship of responsible party to participant:

Please send bills to:

Name: _____ Relationship to participant: _____

Address: _____ City _____ Zip _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____

In the event of an emergency, we will supply the following documents to Emergency Medical Personnel.

Advance Directive, DNR or POLST provided: Yes No

SCADP Representative Signature: X _____

Print name of SCADP Representative: _____ Date: _____

\$75 enrollment fee collected on: _____ (Date) Initial of SCADP Staff: _____



Dear Adult Day Care Participants and Families:

Senior Concerns Adult Day Care Program receives subsidies from the U.S. Department of Agriculture for meals served to our participants. The funding helps with our food costs and enables us to keep our fees low for you, our participants, and your families.

WE NEED YOUR HELP so we can continue to receive these subsidies.

The attached form is required by the U.S. Department of Agriculture for all participants in our Adult Day Care Program. If your primary language is not English, you have a right to ask us for written or oral translation of these materials free of charge in your native language.

Please complete and return the attached form as soon as possible. Your household income determines the funding amount to be received by Senior Concerns. Please complete the entire document.

All information provided will be held in strictest confidence and will be used *only for internal accounting and statistical purposes.*

Please complete the entire form and turn it into me. You may also drop the form off at the Center no later than 7 business days after enrollment in Senior Concerns Adult Day Center. If you need help filing out the form, please call Lisa Weaver, at 805-497-0189.

Thank you in advance for your cooperation.

Sincerely,

Lisa Weaver, MS, RD
Director of Nutrition Services for Adult Day Center

Non-Discrimination Statement

In accordance with federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, DC 20250-9410 or call 866-632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through Federal Relay Service at 800-877-8339, or 800-845-6136 (Spanish). The USDA is an equal opportunity provider and employer.

Senior Concerns is a 501(c)(3) Non Profit Corporation Tax ID number 95-2992927
401 Hodencamp Road, Thousand Oaks, CA 91360 805.497.0189

**MEAL BENEFIT FORM FOR ADULT PARTICIPANTS
PROGRAM YEAR 2018-2019**

Name of Adult Care Center: Conejo Valley Senior Concerns

Please read the instructions. If you need help completing this form, call: Lisa Weaver @ 805-497-0189. Complete, sign, and return form to: Senior Concerns @ 401 Hodencamp Rd, Thousand Oaks, CA 91360.

1. PARTICIPANT INFORMATION

Enter the names of any adult participants from the same household who are enrolled for care. If the participant receives Medicaid/Medi-Cal or Supplemental Security Income (SSI) benefits, provide the case number below. If all participants listed below have a case number, go to Section 4 and sign this form.

Last Name	First Name	Middle Initial	Medicaid/Medi-Cal or SSI Case Number

2. BENEFITS

If anyone in the household receives CalFresh or Food Distribution Program on Indian Reservations (FDPIR) benefits, list the case number and. **do not** complete Section 3. Go to Section 4

Program	Case Number
CalFresh	
FDPIR	

3. ALL OTHER HOUSEHOLDS

Complete this section if you did not complete Section 2. List all household members, spouse, and any dependent children of the participant(s). List total household gross income and how often it is received (e.g., weekly, every two weeks, twice a month, monthly, or annually).

Check here if this household receives no income. _____ Go to Section 4.

Applicants without income must write a **zero** in the applicable field or mark **no income**. Any income field left blank is a positive indication of no income and certifies that there is no income to report. Applications with blank income fields will be processed as complete.

Names of all household members, including adult participant(s)	Earnings from work before deductions	Child support, alimony	Payments from pensions, retirement, Social Security	Earnings from any other income
Example: Janet Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$0
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$

4. LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (SSN) AND SIGNATURE

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the Medicaid/Medi-Cal, SSI benefits, CalFresh, or FDPIR case number is current and correct, or that all income is reported. I understand that this information is being given for the receipt of federal funds; that agency officials may verify the information on the Meal Benefit Form (MBF) and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Printed Name: _____

Last Four Digits of SSN: _____ **No SSN:** _____

Signature of Parent/Guardian: _____

Date: _____

PRIVACY ACT STATEMENT

The Richard B. Russel National School Lunch Act (NSLA) requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the SSN of the adult household member who signs the application. The last four digits of the SSN are not required when you list a Supplemental Nutrition Assistance Program (SNAP, or CalFresh), Temporary Assistance for Needy Families (TANF, or CalWORKS) Program, or FDPIR case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a SSN. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for the administration and enforcement of the program.

The last four digits of the SSN may be used to identify the household member in verifying the correctness of the information stated on the form. This may include program reviews, audits and investigations, and may include contacting employers to determine income, contacting a CalFresh, CalWORKs, or FDPIR office to determine current certification for CalFresh, CalWORKs, or FDPIR benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported. The last four digits of the SSN may also be disclosed to programs as authorized under the NSLA and the Child Nutrition Act, the Comptroller General of the United States, and law enforcement officials for the purpose of investigating violations of certain federal, state, and local education, and health and nutrition programs.

5. RACIAL/ETHNIC IDENTITY

You are not required to answer these questions. If you choose to do so, please mark one or more of the following racial identities:

American Indian or Alaskan Native _____
Asian _____
Black or African American _____
Native Hawaiian or Other Pacific Islander _____
White _____

Please mark one of the following ethnic identities:

Hispanic or Latino _____
Not Hispanic or Latino _____

FOR AGENCY USE ONLY

PARTICIPATION ELIGIBILITY

60 years of age or older: Yes ____ No ____

If under 60, qualifying impairment is documented: Yes ____ No ____

PARTICIPATION ELIGIBILITY—RESIDENCE

Lives in own residence: Yes ____ No ____

Lives with family members: Yes ____ No ____

Board and care (for supervision or monitoring): Yes ____ No ____

Room and board: Yes ____ No ____

Intermediate Care Facility (ICF)/Developmental Disabled-Habilitative (DDH): Yes ____ No ____

ICF/DDH: **(Not eligible to participate)**: Yes ____ No ____

Skilled Nursing Facility **(Not eligible to participate)**

CATEGORICAL ELIGIBILITY

CalFresh/FDPIR household categorically eligible free? Yes ____ No ____

Medicaid/Medi-Cal or SSI categorically eligible free? Yes ____ No ____

INCOME ELIGIBILITY

Annual Conversion (required if household reports various pay frequencies in Section 3): Weekly times (x) 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

ELIGIBILITY CLASSIFICATION

Total Household Income and Frequency: \$ _____ per _____

Household Size _____

Determining Official Name: _____

Determining Official Signature: _____ Date: _____

Eligibility Classification: Free _____ RP _____ Base _____

HOW TO COMPLETE THE MEAL BENEFIT FORM

1. PARTICIPANT INFORMATION

- a. Print the participant's name.
- b. If applicable, provide the participant's Medicaid/Medi-Cal or SSI number.
- c. If you provide a case number, skip to Section 4 and sign the form. You do not have to provide an SSN.

2. **BENEFITS:** Complete this section, then skip to Section 4 and sign the form.

- a. If applicable, provide the current CalFresh or FDPIR case number(s) for any member of the household.
- b. If you provide a case number, skip to Section 4 and sign the form. You do not have to provide an SSN.
- c. If you did not provide a case number in either Section 1 or 2, you must complete Section 3.

3. **ALL OTHER HOUSEHOLDS:** Complete this section only if you do not have a case number.

- a. Write the names of each participant, spouse, and any dependent children of the participant(s) in your household, even if they do not have an income.
- b. Write the amount of income each person received last month before taxes or anything else was taken out **and** where it came from, such as earnings, pensions, and other income (see examples below for types of income to report). Each income amount should be entered in the appropriate column on the form. If any amount **last month** was more or less than usual, write that person's usual monthly income.
- c. If anyone is self-employed, write the amount of income that person earns from self-employment. Please call the number listed at the top of the form if you need help.
- d. Sign the form and include the last four digits of your SSN in Section 4. If you do not have an SSN, place a checkmark next to **No SSN**.

4. LAST FOUR DIGITS OF SSN AND SIGNATURE:

- a. The form must have the signature of an adult household member.
- b. The participant or adult household member who signs the statement must include the last four digits of his or her SSN. If they do not have an SSN, they will place a checkmark next to **No SSN**.
- c. The last four digits of the participant's or adult household member's SSN is not needed if a CalFresh, FDPIR, Medicaid/Medi-Cal, or SSI case number is provided.

RACIAL/ETHNIC IDENTITY: You are not required to answer this question to get meal benefits, but completion of this information will help ensure that everyone is treated fairly.

INCOME TO REPORT

Earnings from Work

- Wages/salaries/tips
- Strike benefits
- Unemployment compensation
- Worker's compensation
- Net income from self-employment

Child Support/Alimony

- Public assistance payments
- Alimony/child support payments

Pensions/Retirement/Social Security

- Pensions
- Supplemental security income
- Retirement income
- Veteran's payments
- Social Security

Other Monthly Income

- Disability benefits
- Cash withdrawn from savings
- Interest dividends
- Income from estates/trusts/investments
- Regular contributions from persons not living in the household
- Net royalties/annuities/net rental income
- Military allowance for off-base housing
- Any other income

DESCRIPTION OF RACIAL AND ETHNIC CATEGORIES

The federal government has established the following five racial categories and one ethnic category:

RACE

American Indian or Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American—A person having origins in any of the black racial groups of Africa. Terms such as "**Haitian**" or "**Negro**" can be used in addition to "**Black or African American**."

Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY

Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term **Spanish origin** can be used in addition to "**Hispanic or Latino**."

Not Hispanic or Latino

U.S. DEPARTMENT OF AGRICULTURE NONDISCRIMINATION STATEMENT

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
2. Fax: 202-690-7442
3. Email: program.intake@usda.gov

This institution is an equal opportunity provider.



401 Hodencamp Road Thousand Oaks, California 91360
(805) 497-0189

Emergency Medical Care Authorization and Release from Liability

While visiting and/or participating in Senior Concerns Adult Day Program, I hereby authorize the following procedures to be initiated in case of medical emergency, and I take full responsibility for any and all expenses incurred. The authorized staff member of Senior Concerns Adult Day Program will:

1. Arrange for emergency transportation to the first available medical facility, by dialing 911.
2. Contact the primary caregiver/responsible party and/or the emergency contact as listed on the contact form.

According to California Department of Social Services Community Care Licensing Division, we are required to call 911, therefore we do not honor DNR requests.

If you provide us a copy of a DNR, POLST, 5 Wishes or DPA for Health Care, in the event of an emergency, we will give a copy to the 911 responders.

I hereby agree to release the Adult Day Program, its staff or agents and all volunteers from liability. In the event of an emergency or accidents occurring in the premises of Senior Concerns, or while on an outing or Field Trip, I authorize treatment by any licensed physician or medical personal. I understand that Senior Concerns Adult Day Program will make a reasonable effort to contact the primary caregiver/responsible party.

Participant Name (Printed)

Caregivers Name (Printed)

Relationship to Participant

X

Caregiver's Signature

Caregiver's Address

City & State

Caregiver's Phone Number

Date

PREPLACEMENT APPRAISAL INFORMATION
Admission - Residential Care Facilities

NOTE: *This information may be obtained from the applicant, or his/her authorized representative. (Relatives, social agency, hospital or physician may assist the applicant in completing this form.) This form is not a substitute for the Physician's Report (LIC 602).*

APPLICANT'S NAME

AGE

HEALTH (Describe overall health condition including any dietary limitations)**PHYSICAL DISABILITIES** (Describe any physical limitations including vision, hearing or speech)**MENTAL CONDITION** (Specify extent of any symptoms of confusion, forgetfulness; participation in social activities (i.e., active or withdrawn))**HEALTH HISTORY** (List currently prescribed medications and major illnesses, surgery, accidents; specify whether hospitalized and length of hospitalization in last 5 years)**SOCIAL FACTORS** (Describe likes and dislikes, interests and activities)**BED STATUS**

- ☐ OUT OF BED ALL DAY
☐ IN BED ALL OR MOST OF THE TIME
☐ IN BED PART OF THE TIME

COMMENT:

TUBERCULOSIS INFORMATION

ANY HISTORY OF TUBERCULOSIS IN APPLICANT'S FAMILY?

- ☐ YES ☐ NO

DATE OF TB TEST

- ☐ POSITIVE
☐ NEGATIVE

ANY RECENT EXPOSURE TO ANYONE WITH TUBERCULOSIS?

- ☐ YES ☐ NO

ACTION TAKEN (IF POSITIVE)

GIVE DETAILS

AMBULATORY STATUS (this person is ☐ ambulatory ☐ nonambulatory)

Ambulatory means able to demonstrate the mental and physical ability to leave a building without the assistance of a person or the use of a mechanical device.

An ambulatory person must be able to do the following:

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane. |
| <input type="checkbox"/> | <input type="checkbox"/> | Mentally and physically able to follow signals and instructions for evacuation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Able to use evacuation routes including stairs if necessary. |
| <input type="checkbox"/> | <input type="checkbox"/> | Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation). |

FUNCTIONAL CAPABILITIES (Check all items below)

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Active, requires no personal help of any kind - able to go up and down stairs easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Active, but has difficulty climbing or descending stairs |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses brace or crutch |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeble or slow |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses walker. If Yes, can get in and out unassisted? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses wheelchair. If Yes, can get in and out unassisted? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | <input type="checkbox"/> | Requires grab bars in bathroom |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: (Describe) _____ |

SERVICES NEEDED (Check items and explain)

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Help in transferring in and out of bed and dressing _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with bathing, hair care, personal hygiene _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does client desire and is client capable of doing own personal laundry and other household tasks (specify) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with moving about the facility _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with eating (need for adaptive devices or assistance from another person) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Special diet/observation of food intake _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Toileting, including assistance equipment, or assistance of another person _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Continence, bowel or bladder control. Are assistive devices such as a catheter required? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help with medication _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Needs special observation/night supervision (due to confusion, forgetfulness, wandering) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help in managing own cash resources _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Help in participating in activity programs _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Special medical attention _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Assistance in incidental health and medical care _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other "Services Needed" not identified above _____ |

Is there any additional information which would assist the facility in determining applicant's suitability for admission?

☐ Yes

☐ No

If Yes, please attach comments on separate sheet.

To the best of my knowledge, I (the above person) do not need skilled nursing care.

SIGNATURE

DATE COMPLETED

APPLICANT (CLIENT) OR AUTHORIZED REPRESENTATIVE

SIGNATURE

DATE COMPLETED

LICENSEE OR DESIGNATED REPRESENTATIVE

DATE COMPLETED



401 Hodencamp Road Thousand Oaks, California 91360
(805) 497-0189

Intake Questionnaire

Today's Date: _____

Participant Name: _____

1	Place of birth and ethnicity:
2	Brothers and Sisters:
3	Education:
4	Marriage:
5	Children and Grandchildren:
6	Work History:
7	Special Skills, Hobbies and Interests:
8	Achievements, Accomplishments, Awards:
9	Clubs and or Organizations:
10	Places Lived:
11	Family Traditions:
12	Religious Involvement:
13	Travels:
14	Pets:



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(805) 497-0189

Client Services Information

Participant Name: _____ Age: _____ Birthdate: ____/____/____
 Today's Date: _____

ACTIVITIES (ADLS) & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING

Please check (✓) one of the columns for each activity

TYPE OF ASSISTANCE NEEDED TO PERFORM TASK→		1 - INDEPENDENT Needs No Help	2 - VERBAL QUE Needs Verbal Reminders	3 - STAND BY Needs some Human Help	4 - HANDS ON Needs Lots of Human Help	5 - DEPENDENT Cannot perform task; relies on others
A D L S	EATING					
	DRESSING					
	TRANSFERRING					
	BATHING					
	TOILETING					
	GROOMING					
	WALKING					
I A D L S	LIGHT HOUSEWORK					
	DOING LAUNDRY					
	SHOPPING/ERRANDS					
	MEAL PREP/CLEANUP					
	TRANSPORTATION					
	USING TELEPHONE					
	MANAGING MEDICATIONS					
	MANAGING MONEY					
	STAIR CLIMBING					
	HEAVY HOUSEWORK					

RACE - PLEASE CHOOSE (✓) ONE:

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Multiple Race _____ |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Other Pacific Islander _____ |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White |
| <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Declined to State |

INCOME LEVEL - PLEASE CHOOSE (✓) ONE:

- | | |
|--|--|
| <input type="checkbox"/> < \$18,000 | <input type="checkbox"/> \$30,000 - \$48,000 |
| <input type="checkbox"/> \$18,000 - \$30,000 | <input type="checkbox"/> >\$48,000 |

GENDER: ☐ MALE ☐ FEMALE

PARTICIPANT'S PREFERRED LANGUAGE IF OTHER THAN ENGLISH - _____

LIVING ARRANGEMENTS:

- | | |
|---|--|
| <input type="checkbox"/> In Own Home | <input type="checkbox"/> Lives in Own Home with Caregiver |
| <input type="checkbox"/> In Own Home with Spouse | <input type="checkbox"/> Lives in Own Home with Adult Child |
| <input type="checkbox"/> Lives in Home of Adult Child | <input type="checkbox"/> Lives in Senior Care Facility _____ |

TOTAL NUMBER IN HOUSEHOLD: _____



401 Hodencamp Road Thousand Oaks, California 91360
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Consent for Photographs and/or Videos General Release Form

General Release to Senior Concerns

I hereby grant permission to Senior Concerns, its affiliates, and their successors, and any person receiving permission from them to use my picture likeness, name, photograph, video and voice, to use and publish copies there of in various formats, and to authorize publication of the fact that it is my picture likeness, name, photograph or voice.

I further grant permission for Senior Concerns to use information obtained by survey, questionnaire, seminar, evaluation form or other written communication to document grant applications, statistical record keeping or for such other purposes as deemed necessary by the Program Director. I understand that my name will not be used for such purpose and all information specific to my case file will remain confidential.

I agree that I will not hold Senior Concerns responsible for any liability from use.

Participant Name (Printed)

Caregivers Name (Printed)

Relationship to Participant

 X

Caregiver's Signature

Caregiver's Address

City & State

Caregiver's Phone Number

Date

I DO NOT authorize photographs/videos _____

PERSONAL RIGHTS
ADULT COMMUNITY CARE FACILITIES

EXPLANATION: The California Code of Regulations, Title 22 requires that any person admitted to a facility must be advised of his/her personal rights. Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of persons admitted to facilities and the facility owners who are required to post these rights.

This form describes the personal rights to be afforded each person admitted to an adult community care facility. The form also provides the complaint procedures for the client and representative/conservator. The facility staff or client representative must communicate these rights in a manner appropriate for client's ability.

This form is to be reviewed, completed and signed by each client and/or each representative/conservator upon admission to the facility. The client and/or representative/conservator also has the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the client's file which is maintained by the facility.

TO: CLIENT OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: At the time of admission I have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22.

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

Senior Concerns Adult Day Center

401 Hodencamp Rd, Thousand Oaks, CA 91360

(PRINT THE NAME OF THE CLIENT)

(SIGNATURE OF THE CLIENT)

(DATE)

(SIGNATURE OF THE REPRESENTATIVE/CONSERVATOR)

(TITLE OF THE REPRESENTATIVE/CONSERVATOR)

(DATE)

THE CLIENT AND/OR THE REPRESENTATIVE/CONSERVATOR HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS. THIS AGENCY IS:

NAME

North Los Angeles and Central Coast Adult and Senior Care Regional Offices

ADDRESS

21731 Ventura Boulevard, #250

CITY

Woodland Hills, CA

ZIP CODE

91364

AREA CODE/TELEPHONE NUMBER

(818) 596-4248

PERSONAL RIGHTS

ADULT COMMUNITY CARE FACILITIES

Each client shall have rights, which include, but are not limited to the following:

- (1) A right to be treated with dignity, to have privacy and to be given humane care.
- (2) A right to have safe, healthful and comfortable accommodations, including furnishings and equipment to meet your needs.
- (3) A right to be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature. To be free from restraining devices, neglect or excessive medication.
- (4) A right to be informed by the licensee of provisions in the law regarding complaints, including the address and telephone number of the licensing agency, and of information regarding confidentiality.
- (5) A right to attend religious services and activities . Participation in religious services and other religious functions shall be on a completely voluntary basis.
- (6) A right to leave or depart the facility at any time, and to not be locked into any room or building, day or night. This does not prohibit the development of house rules, such as the locking exterior doors or windows, for the protection of the consumer.
- (7) A right to visit a facility with a relative or authorized representative prior to admission.
- (8) A right to have communications between the facility and your relatives or authorized representative answered promptly and completely, including any changes to the needs and services plan or individual program plan.
- (9) A right to be informed of the facility's policy concerning family visits. This policy shall encourage regular family involvement and provide ample opportunities for family participation in activities at the facility.
- (10) A right to have visitors, including advocacy representatives, visit privately during waking hours provided the visits do not infringe upon the rights of other consumers.
- (11) A right to possess and control your own cash resources.
- (12) A right to wear your own clothes, to possess and use your own personal items, including your own toilet articles.
- (13) A right to have access to individual storage space for your private use.
- (14) A right to have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of the telephone in emergencies.
- (15) A right to promptly receive your unopened mail.
- (16) A right to receive assistance in exercising your right to vote.
- (17) A right to receive or reject medical care or health-related services, except for those whom legal authority has been established.
- (18) A right to move from a facility in accordance with the terms of the admission agreement.

Reference:

California Code of Regulations, Title 22, Division 6 - General Licensing Regulations, Section 80072; Section 81072, Social Rehabilitation Facilities; Section 85072, Adult Residential Facilities; Section 87872, Residential Care Facilities for the Chronically III.



401 Hodencamp Road Thousand Oaks, California 91360
(805) 497-0189

Nondiscrimination Statement Child and Adult Care Food Program (CACFP)

Senior Concern's Adult Day Care Program receives subsidies from the U.S. Department of Agriculture for meals served to our participants. This funding helps with our food costs and enables us to keep our fees low.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish).

"USDA is an equal opportunity provider and employer."

Participant Name (Printed)

Caregivers Name (Printed)

Relationship to Participant

X

Caregiver's Signature

Date



Adult Day Program
**POLICY FOR MISSING PERSONS NOTIFICATION PLAN
FOR AB 620 COMPLIANCE**

I. PURPOSE

To increase the safety of participants and comply with AB620 (Chapter 674 Statutes of 2013), which requires notification of the participant's authorized representative, as well as law enforcement in certain situations, when a participant is determined to be missing from the facility.

II. POLICY

It is the policy of Senior Concerns to notify a participant's authorized representative, as well as local law enforcement under certain circumstances, should a participant be identified as missing from the facility, as defined in law and described below.

III. DEFINITIONS

A. Missing Person:

"Absent/physically missing" on a regular day of attendance is defined to mean that:

1. the individual arrived at the Center for a day of attendance and was visually confirmed to be present, but was subsequently identified as missing from the Center's premises without the knowledge of the staff; and
2. the participant's whereabouts remained unknown to the staff after efforts were made to locate him or her.

B. Non-Attendance:

This policy does not apply to non-attendance at the adult day services program on a scheduled day (i.e., a day on which the participant has not entered the premises of the adult day services facility). Other regulations address the requirement that the adult day services staff must follow up whenever the participants are absent without notice (i.e., have not called to cancel, but do not show at the program) on scheduled days of attendance.

C. Local Law Enforcement:

Local law enforcement is defined to mean the law enforcement agency with jurisdiction in the area where Conejo Valley Senior Concerns, Inc. is located.

IV. PROCEDURES

- A. Upon enrollment in Senior Concerns, all participants who have a legally designated “authorized representative” (defined as a conservator, guardian or durable power of attorney for health care) will have that representative identified in their ADP health record as part of the personalized Absentee Notification Plan that is required component of their ADP Needs and Services Plan.
- B. The Absentee Notification Plan specifies that the participant’s authorized representative will be contacted by the program administrator or his or her designee (defined as the administrator, program director, or other designated managerial representative for the adult day services program) should the participant ever be absent (i.e., physically missing) from the Center on a regular day of attendance.
- C. If the absent participant cannot be located after a reasonable search of the adult day services premises and close vicinity, or through a call or visit to his or her home, law enforcement will be contacted as soon as possible, and no later than that same program day, in cases where;
 - 1) the authorized representative cannot be reached;
 - 2) there is agreement with the authorized representative that law enforcement should be contacted;
or
 - 3) it is the judgment of the administrator and/or program director that law enforcement should be contacted due to the health or psychosocial needs of the participant or other identified concerns.
- D. The adult day services [social worker or position of other designated staff person] is responsible for placing the “Absentee Notification Form” in the front of the participant’s chart when completed and provide a copy to the authorized representative. Contact information for the participant’s authorized representative must be kept current on the participant’s emergency information card.



Adult Day Program

ABSENTEE NOTIFICATION PLAN

Participant Name: _____

Participant's Authorized Representative and nature of authority:

Date of participant's enrollment: _____

Procedure to follow if the participant is found to be missing from the center on a day of attendance:

1. Requirement to contact the authorized representative:

The Participant's authorized representative must be contacted by a Center administrator (the administrator, acting administrator, program director or designee) if the participant ever becomes absent from the Center on a regular day of attendance.

A regular day of attendance is defined as a day on which:

- (A) The participant arrived at the Center for a day of attendance, but subsequently was found to be missing from the Center without staff knowledge of his or her departure or whereabouts, if he or she can't be located after a reasonable search of the Center premises and vicinity; and
- (B) The participant's whereabouts remain unknown to the Center staff after efforts are made to locate him or her both on and off the premises.

2. Requirement to contact law enforcement:

Law enforcement with jurisdiction over the area where the Senior Concerns Adult Day Care services program is located will be contacted as soon as possible, and not later than that same program day, in cases where:

- 1) The authorized representative cannot be reached; or
- 2) There is agreement with the authorized representative that law enforcement should be contacted; or
- 3) It is the judgment of the administrator and/or program director that law enforcement should be contacted due to the health or psychosocial needs of the participant or other identified concerns.

3. A copy of this form has been provided to the participant's authorized representative.

Caregiver Signature: _____

Date: _____

ADC DIET and NUTRITION QUESTIONNAIRE

NAME _____

DOB _____

ADC Start Date _____

Please check any of the following that apply:

☐ Food Allergy *If so, please state the food(s): _____

☐ Diabetes *If so, please state Doctor Recommendations: _____

☐ Lactose Intolerance *If so, please state the food(s) NOT tolerated: _____

☐ Difficulty Chewing/Swallowing

☐ Need Soft Diet

☐ Need Chopped Diet

☐ Need Pureed Diet

☐ Difficulty Holding Utensils (prefer Finger Foods)

☐ Prefer Small Portions

☐ Food Intolerance *If so, please state the food(s): _____

☐ Other Diet Concern: _____

****NOTE:** All Meals and Snacks are *Heart Healthy*: Low in fat, salt and sugar.