Senior Concerns
Serving Seniors & Their Families

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	☐	Poor Hearing	☐
High Blood Pressure	☐	Hearing Aid	☐
History of Falling	☐	Heart Condition	☐
Poor Vision	☐	Pacemaker	☐
Wears Glasses	☐	Osteoporosis	☐

Medication Allergies: _____

Other Allergies: _____

Veteran Status Yes ☐ No ☐ Branch: _____

Emergency Contacts / Persons Authorized to Pick-up Participant

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

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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:

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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: _____

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: `Conejo Valley Senior Concerns Adult Day Care Center

TELEPHONE: 805-497-0189

ADDRESS: NUMBER: 401 STREET: Hodencamp Rd CITY: Thousand Oaks, CA 91360

LICENSEE'S NAME: Senior Concerns

TELEPHONE:

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:

SECONDARY DIAGNOSIS:

LENGTH OF TIME UNDER YOUR CARE:

AGE: HEIGHT: SEX: WEIGHT:

IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE

DATE OF LAST TB TEST:

TYPE OF TB TEST USED:

TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ 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: ☐ GOOD ☐ FAIR ☐ POOR	YES (Check One)	NO (Check One)	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: ☐ GOOD ☐ FAIR ☐ POOR	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: ☐ YES ☐ NO	YES (Check One)	NO (Check One)	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	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

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:

Senior Concerns
Serving Seniors & Their Families

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, discussion and reminiscence groups, music, entertainment, modified exercises, gardening, religious group activities, visiting pets and other person-centered activities.

B) Assistance with some Activities of Daily Living (scheduled restroom breaks and guidance). This can include assistance in the restroom by one staff member, assistance with transferring, supervision while walking, meal preparation and chopped meals if needed.

C) Nutritious lunches and snacks as needed are provided daily.

F) Daily observation of participant's general health.

G) Care Management (by appointment).

H) Information and Referral as needed. This includes coordination with our Care Manager who can work with the family individually to assist them with resources and care plans related to caregiving issues.

I) Caregiver Education Programs.

II. Optional Services Available:

1. Special needs diet.
2. 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 the time and amount to be delivered prior to being dispensed at the Center.
3. Assistance in the bathroom by one staff member. 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.

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.

The program is geared for participants who may need some care and supervision due to cognitive or physical impairments, but who can also still benefit from the activities and socialization the program provides. 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 wheelchair 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.

IV. Forms required prior to attending program:

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

V. Family Involvement and Participation:

Family participation is welcomed. The Team Lead will communicate regularly with the family to report back on any observed changes or issues. The family member and primary caregiver is encouraged to provide feedback to the Team Lead as well to ensure the program can meet the participants needs.

VI. Attendance:

A minimum attendance of at least two days per week is recommended 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 10:00 AM to 2:00 PM.** No extended care is currently offered.

We ask that participants adhere to their scheduled days of attendance. **SCADP requires a two week notice if *exiting the program*.**

- Changes in participants attendance should be submitted in writing to the Program Lead or Program Director by signing a new fee schedule to reflect the change in schedule.
- No make-up days or credits/refunds are provided for missed days of attendance.
- Should a participant leave SCADP temporarily, a one-month hold may be placed on the file. After one month's 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.

VII. 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.
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.

VIII. 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 yearly and again when there is a change in functioning, and an Updated List of Medications as often as necessary.

IX. 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, and schedule rides as needed. Please communicate the schedule of rides to SCADP staff.

It is the responsibility of both the Participant and Responsible Party to adhere to the rules and regulations of the transportation services.

X. 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.

XI. Wander Guard and Delayed Egress Doors:

All exit doors from the Senior Concerns Adult Day program to the outside either have an alarm that will sound upon opening or have a delayed egress alarm. A delayed egress alarm means that upon pushing continuously on the door for 15 seconds the door will open and signal an alarm. A sign is posted on all delayed egress doors that states "Keep pushing. This door will open in 15 seconds. An alarm will sound". This is a safety and security measure. The only door that has no alarm on its own is the front entrance. Participants wear a sensor battery (wander guard system) in

their name badges to signal an alarm if they pass through the front door. Additionally, the front door is always monitored by a staff member.

XII. 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. For those times you do not know in advance, please call as soon as possible. No make-up days or billing credits are available.

XIII. 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 safekeeping.

XIV. 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.

XV. 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.

XVI. Grievance Procedure:

SCADP is committed to providing you and your loved-one with 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.

XVII. Exit Criteria/Discharge/Conditions Under Which This Agreement May be Terminated:

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 have become so incapacitated as to lose the ability to benefit from our services.
- Participants 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.
- Participants refusal to cooperate with the implementation of his/her Needs and Services Plan.

SCADP will provide a 2 week 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.

VIII. Billing:

An Adult Day Services Fee Schedule signed by the Responsible Party is required prior to admission. Participants are billed a monthly fee based on the schedule specified in the signed agreement. The bill must be paid prior to the month of attendance.

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.

Basic Rate:

Monthly fees are based on the number of days per week scheduled. The rates are as follows:

- 5 days a week from 10am – 2pm daily is a monthly rate of $1500.
- 4 days a week from 10am – 2pm is a monthly rate of $1200.
- 3 days a week from 10 am – 2pm is a monthly rate of $900.
- 2 days a week from 10am – 2pm is a monthly rate of $600.
- 1 day a week from 10am – 2pm is a monthly rate of $300.

Optional Services Rate: There are no optional Senior Concerns fees. The only added fee is in the event that the client is not picked up on time. There is a ten-minute grace period for drop off (starting at 9:50am) and pick up (until 2:10pm). If the client is picked up after 2:10 pm a daily late fee of $25 will be added to your bill. If late pick up continues regularly, then participant may not be able to continue enrollment in the program.

Payor:

The client representative is responsible for on-time payment. Any Long Term Care Insurance Plan or outside grants will reimburse the client representative unless arrangements are made directly with the finance department.

Due Date and Frequency of Payment:

The monthly fee is due on the 20th day of the month for the subsequent month. SCADP encourages automatic credit card payments for on-time payments for our services. To ensure ongoing participation in the SCADP, on-time payments are required.

Refund Conditions: No refunds are provided for missed days due to holidays, sickness or natural disaster. If the client representative provides a 2 week notice for leaving the program, then the pre-paid month will be refunded pro-rated for the time 2 weeks from notice. For example, if notice is provided on the fifth of the month, then 2 weeks will be to

the 19th of the month. A refund for the time from the 19th to the end of the month will be provided. If the client passes away unexpectedly then a refund for the remaining time on the month will be provided.

Modification Conditions for Billing Rate: Senior Concerns will not make any changes to the billing procedures and rate without providing a minimum of 30-day notice in writing to the client and/or authorized representative.

XIX. Scholarships:

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

XX. Evaluation Visits and Inspection Authority of the Licensing Agency:

The licensing agency (Community Care Licensing) has the right to evaluate and inspect the Adult Day Program pursuant to the authority specified in Health and Safety Code Sections 1526.5, 1533, 1534 and 1538. The licensing agency has the authority to interview clients or staff members without prior consent. The licensing agency has the authority to inspect, audit and copy client or facility records upon demand during normal business hours. Records may be removed if necessary for copying.

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 participant's condition and/or medications. Medication and Condition Change Forms are available upon request.

Senior Concerns
Serving Seniors & Their Families

ADMISSION CONTRACT

- I agree to pay according to the attached schedule.
- Transportation will be coordinated by the family and provided by:_____.
- I understand that I will be billed for my agreed upon days on a monthly basis. I will be billed on the 1st day of the month for the following month, with payment due 10 days before the 1st day of the month of service.
- Additional days will be invoiced accordingly.
- Credit Card Payment is available. If you would like to have automatic payment, please log into Procare and set up recurring payments.
- 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 Name of 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:_____

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. Senior Concerns Adult Day Care Center is considered an essential service and have put in place preventative measures and recommendations to reduce the spread of COVID-19. However, the Centers cannot guarantee that you or your family member will not become infected with COVID-19. Further, attending the Centers could increase your risk and your family member's risk of contracting COVID-19.

****

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my family member and I may be exposed to or infected by COVID-19 by attending the Centers and that such exposure or infection may result in personal injury, illness, permanent disability, and death

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my family member or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my family member may experience or incur in connection with my family member's attendance at the Center or participation in Center programming ("Claims"). On my behalf, on behalf of my family member and all heirs, I hereby release, covenant not to sue, discharge, and hold harmless the Center, its employees, volunteers, agents, Officers, Board of Directors, representatives and contractors, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the Center, its employees, agents, representatives and contractors, whether a COVID-19 infection occurs before, during, or after participation in any Center program.

_____ _____

Signature of Responsible Party Date

_____ _____

Print Name of Responsible Party Name of Center Participant

Senior Concerns
Serving Seniors & Their Family Caregivers

Adult Day Care Program Fee Schedule

805-497-0189

Participant Name: _____

Select Weekly Attendance (check one):	**Days Scheduled to Attend (10am – 2pm):**
☐ 1 Day a Week – **$300/month**	☐ Monday
☐ 2 Days a Week – **$600/month**	☐ Tuesday
☐ 3 Days a Week – **$900/month**	☐ Wednesday
☐ 4 Days a Week – **$1,200/month**	☐ Thursday
☐ 5 Days a Week – **$1,500/month**	☐ Friday

- Lunch is included in your monthly fee. Transportation is separate and coordinated by the family. No early or late care is offered.
- Invoices will be sent to your email on the 1st of the month for the subsequent month with payment due ten days prior to the end of that month. Automatic billing via ACH or a credit card on file is the preferred payment method.
- There are no makeup days or changes to this schedule. This includes if the center is closed for a Holiday or unavoidable reason.
- There is a ten-minute grace period for drop off (starting at 9:50am) and pick up (until 2:10pm).
- If you pick up your loved one after 2:10pm a daily late fee of $25 will be added to your bill. If late pickups continue regularly, then staff may not be able to continue your enrollment in the program.

By signing below, you agree to have read, understood and to follow the Fee Schedule agreement.

Monthly Fee: $_____

Participant Representative Name Printed: _____

Relationship to Participant: _____

Signature: _____ Date: _____

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	
		Able to walk without any physical assistance (e.g., walker, crutches, other person), or able to walk with a cane.
		Mentally and physically able to follow signals and instructions for evacuation.
		Able to use evacuation routes including stairs if necessary.
		Able to evacuate reasonably quickly (e.g., walk directly the route without hesitation).

FUNCTIONAL CAPABILITIES (Check all items below)

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

SERVICES NEEDED (Check items and explain)

YES	NO	
		Help in transferring in and out of bed and dressing
		Help with bathing, hair care, personal hygiene
		Does client desire and is client capable of doing own personal laundry and other household tasks (specify)
		Help with moving about the facility
		Help with eating (need for adaptive devices or assistance from another person)
		Special diet/observation of food intake
		Toileting, including assistance equipment, or assistance of another person
		Continence, bowel or bladder control. Are assistive devices such as a catheter required?
		Help with medication
		Needs special observation/night supervision (due to confusion, forgetfulness, wandering)
		Help in managing own cash resources
		Help in participating in activity programs
		Special medical attention
		Assistance in incidental health and medical care
		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

Senior Concerns
Serving Seniors & Their Families

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

Intake Questionnaire

Please include as much information as you would like to share.

This background information is useful for our staff to get to know your loved one and how to best create activities around their interests and engage with them in conversation.

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	Travels:
9	Pets:
10	Places Lived:
11	Family Traditions:
12	Religious Involvement:
13	Activities They Enjoy:
14	Topics to Avoid:

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Client Services Information

Participant Name: _____ Age: _____ Birthdate: ___/___/___

Todays' Date: _____

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

Please check (✓) one of the colums 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
ADLS	EATING					
	DRESSING					
	TRANSFERRING					
	BATHING					
	TOILETING					
	GROOMING					
	WALKING					
IADLS	LIGHT HOUSEWORK					
	DOING LAUNDRY					
	SHOPPING/ERRANDS					
	MEAL PREP/CLEANUP					
	TRANSPORTATION					
	USING TELEPHONE					
	MANAGING MEDICATIONS					
	MANAGING MONEY					
	STAIR CLIMBING					
	HEAVY HOUSEWORK					

RACE - PLEASE CHOOSE (✓) ONE:

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Hawaiian
- ☐ Multiple Race _____
- ☐ Other Pacific Islander
- ☐ White
- ☐ Declined to State

INCOME LEVEL - PLEASE CHOOSE (✓) ONE:

- ☐ < $18,000
- ☐ $18,000 - $30,000
- ☐ $30,000 - $48,000
- ☐ >$48,000

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER: _____

LIVING ARANGEMENTS:

- ☐ In Own Home
- ☐ In Own Home with Spouse
- ☐ Lives in Home of Adult Child
- ☐ Lives in Own Home with Caregiver
- ☐ Lives in Own Home with Adult Child
- ☐ Lives in Senior Care Facility _____

TOTAL NUMBER IN HOUSEHOLD:_____

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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

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 Ill.

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 Blvd., #250

CITY	ZIP CODE	AREA CODE/TELEPHONE NUMBER
woodland Hills	91364	(818) 596-4248

Senior Concerns
Serving Seniors & Their Families

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 Statues 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 into 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 by 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 indentified 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.

Senior Concerns
Serving Seniors & Their Families

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 enforment:**

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 authorizes 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_____

****ADC Meals and Snacks are Heart Healthy:* Lower in fat, no added salt & sugar.**

****Please check any of the following *additional* dietary needs that apply:**

- Food Allergy *If so, please state the food(s):_____
  _____
- Diabetes *If so, please state Doctor Recommendations:
  _____
- Lactose Intolerance *If so, milk can be declined.
- Difficulty Chewing/Swallowing
  - Need Chopped Diet (cut into bite-size pieces)
- Difficulty Holding Utensils (alternative available)
- Prefer Small Portions
- Food Intolerance *If so, please state the food(s):
  _____
  _____
- Other Diet Concern:_____

Senior Concerns will do our best to accommodate the additional dietary needs. If we are unable to meet your loved ones needs or preferences then you may pack a lunch to bring to the program.

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Long Term Care Planning / Advance Directive Checklist

Participant Name:_____ _____ Date:_____

As a courtesy, Senior Concerns would like to be informed if you have any of the following planning information.

- ☐ POLST
- ☐ DNR
- ☐ Power of Attorney for Healthcare
- ☐ Conservatorship
- ☐ 5 Wishes Advanced Directive

Please provide a copy for our files in the event of an emergency, we will provide a copy to the emergency responders.

_____ Initial here if you do not have or do not wish to provide a copy to Senior Concerns.