THE BRIDGE

Alzheimer's
RESOURCE CENTER
& Dementia

Adult Day Center

Admissions Packet

THE BRIDGE ADULT DAY CENTER

VISION STATEMENT

Building meaningful relationships and improving the quality of life of individuals and caregivers affected by Alzheimer's and dementia-related diseases.

MISSION STATEMENT

To offer unwavering support and respite care for adults living with Alzheimer's and dementia-related diseases, and their caregivers. We are committed to helping others by:

- Creating a secure, stimulating environment for individuals with dementia, fostering engagement in a diverse range of activities and social interactions.
- Providing caregivers with regular, scheduled respite opportunities, allowing them to focus on their professional responsibilities and enjoy personal activities thereby enabling them to be more effective and compassionate caregivers.

Adult Day Center
Admissions Packet

The Bridge Adult Day Center, a day program provided by The Bridge Alzheimer's & Dementia Resource Center, is designed to offer essential rest and support for caregivers of individuals with Alzheimer's and related dementias and to foster social engagement for those diagnosed with Alzheimer's disease. Every Friday from 9 A.M. to 3 P.M., individuals with Alzheimer's are warmly welcomed by trained staff and volunteers. The program's activities are carefully designed to promote cognitive stimulation and social interaction, ensuring each visit is purposeful and rewarding.

CRITERIA FOR ADMISSION

Admission to The Bridge Adult Day Center is determined after completion of the following documentation and interview with staff members:

Admissions Paperwork includes:

- Service Agreement
- Admissions Application
- Signed Confidentiality Statement
- Responsible Party Information
- Emergency Medical Care
- Emergency Contact Form
- Consent/Waiver to Participate in Program
- Photography/Video Release
- List of Medications
- Authority to Receive/Release

Additional Criteria:

- The client must be between the ages of 50 – 90 and have a diagnosis or suspected diagnosis of dementia. Minors will not be eligible for admission.
- The client must reside in The Bridge Adult Day Center's geographic service region.
- Medical care is not administered by Adult Day Center staff; therefore, the Client must not require medical treatment such as injections, dressing changes or oral medication administration during the time he/she is at the center.
- Tobacco products are not permitted.
- Client must be able to toilet him/herself.
- Client must be ambulatory. Assistive devices such as walkers and/or canes are allowed.
- Client must be able to feed themselves with little or no assistance.
- Client must not present with aggressive behavioral issues.

THE BRIDGE Alzheimer's RESOURCE CENTER & Dementia

APPLICATION/INDIVIDUAL SERVICE PLAN

Today's Date: _____

Participant Information

Participant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of birth: _____

Marital Status: ☐ Single ☐ Married/Domestic Partner ☐ Widowed

Gender: ☐ Male ☐ Female

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Participant is: ☐ Right-Handed ☐ Left-Handed.

Is Participant a Veteran/Spouse of a Veteran? ☐ Yes ☐ No

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other

Fluent Languages: ☐ English ☐ Spanish ☐ Other_____

Physician Name: _____ Physician Phone: _____

Please select one:

☐ Dementia ☐ Alzheimer's Disease ☐ Mild Cognitive Impairment

☐ Vascular ☐ Parkinson's ☐ Frontal Temporal Lobe Dementia

☐ Lewy Body Dementia

☐ Other Related Dementia: _____

☐ Approximate year of diagnosis: _____

☐ Has not been formally diagnosed; Alzheimer's or other dementia suspected

Caregiver Information

Caregiver's Name: _____

Address: (if different) _____

City: _____ State: _____ Zip: _____

Phone: _____

Who referred you to The Bridge Adult Day Center_____

Which of the following services are the client and/or family currently using? (Check ALL services that are used by either the client and/or caregiver)

☐ Companion, sitter, or friends/neighbors

☐ Homemaker/housekeeping services

☐ Chore Services

☐ Personal Care Services

☐ Home Health Services

☐ Adult Day Care

☐ Transportation services

☐ Case Management/Social Worker

☐ Support Groups

☐ Caregiver Training Programs

☐ Psychological counseling

☐ Group meals/home delivered meals

☐ Respite in a nursing home, adult foster home, or someone else's home

☐ Other service: _____

Participant's Health and Demographic Information:

Number and type of chronic diseases or physical impairments he/she has (check all that apply):

☐ None ☐ Arthritis ☐ Diabetes ☐ COPD

☐ Epilepsy ☐ Heart Disease ☐ Hypertension

☐ Other _____

Does the participant use any of the following appliances or aids? (Check all that apply)

☐ Cane ☐ Walker ☐ Wheelchair ☐ Oxygen

☐ Eyeglasses ☐ Hearing Aid ☐ Dentures (☐ Upper ☐ Lower)

Does the participant have difficulty with food, eating or swallowing? ☐ **Yes** ☐ **No**

If Yes, please describe: _____

Does he/she follow a special diet? ☐ Yes ☐ No

If yes, please describe: _____

Does the client have any allergies? (Includes foods, drugs and environment)

☐ Drugs: _____

☐ Pollen ☐ Dairy Products ☐ Eggs ☐ Insect Bites ☐ Sulfa

☐ Other: _____

Participant Profile

Date: _____

Participant Name: _____

Current Caregiver Name: _____

Relationship to client: ☐ Spouse/Partner ☐ Child ☐ Sibling ☐ Friend ☐ Other Relative

In continuing our practice of person-centered care, please provide us with some information and personal preferences for your loved one. This information helps us understand your loved one to provide the best possible care. Thank you so much!

TELL US ABOUT YOUR FAMILY (please indicate if any of the following family members are deceased)

Parent's Names: _____

Names of Siblings: _____

Name of Spouse/Partner: _____

Children(s) Names & Ages: _____

Grandchildren(s) Names & Ages: _____

Pet's Name(s):_____

TELL US ABOUT YOURSELF

Hometown (where were you born & raised): _____

Highest Educational Level Achieved: _____

Work/Occupation: _____

I enjoy(ed) the following activities:_____

_____

The way I like to awaken and begin my day:_____

_____

I want my caregivers to know (things about me): _____

_____

_____

_____

*Please use the back of this page to add additional history, accomplishments, etc.

Foods that I enjoy: _____

Favorite dessert: _____

Things I DO NOT LIKE: _____

_____

I become anxious/afraid when: _____

_____

Things that calm or soothe me: _____

_____

Things that make me laugh: _____

_____

Religious Preference (including church membership): _____

Preferred Activities (please check all that apply)

☐ Gardening	☐ Arts & Crafts	☐ Cooking/kitchen activities
☐ Bird watching	☐ Music therapy/Singing	☐ Dancing
☐ Exercise	☐ Reading	☐ Socials
☐ Gardening	☐ Spa Day	☐ Puzzles
☐ Bingo	☐ Card games	☐ Pet therapy
☐ Painting	☐ Spiritual activities	☐ Listening to music
☐ Word games	☐ Reminiscing activities	

☐ Other: _____

Emergency Contact Information

Participant's Name: _____

Please list at least two people we can contact in case of emergency.

Emergency Contact #1

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Cell Phone: _____

Emergency Contact #2

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Cell Phone: _____

Optional Emergency Contact

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Cell Phone: _____

Confidentiality Agreement

Information contained in the files/records of The Bridge Adult Day Center, a program of The Bridge Alzheimer's & Dementia Resource Center, is confidential.

All employees and volunteers are required to sign a confidentiality agreement.

How we may use and disclose information about day center center clients
In some circumstances we may use or disclose information about a client's participation in the programs at the respite care center. **These circumstances include:**

To obtain emergency medical treatment

Fundraising Activities: We may contact you as part of our effort to raise funds for The Bridge. We will use your photo or information with your written permission.

As required by law: We will disclose information about clients when required to do so by federal, state, or local law.

To avert a serious threat to health or safety: We may use and disclose information about clients when necessary to prevent a serious threat to his/her health and safety or the health and safety of the public or other person(s). Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health risks: We may disclose information about clients for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability.
- To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a client has been the victim of abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Law Enforcement
We may release client information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime, if, under certain limited circumstances, we are unable to obtain the person's agreement.
- About criminal conduct at the organization
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Confidentiality Agreement (continued)

You have the right to:

Request confidential communications:
For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

A paper copy of this notice: You will be given a copy of this notice upon acceptance into the Adult Day Center, a program of The Bridge Alzheimer's & Dementia Resource Center

I understand and agree with the confidentiality agreement for The Bridge Adult Day Center, a program of The Bridge Alzheimer's & Dementia Resource Center

Caregiver Signature_____**Date** _____

Print Name_____

Responsible Party Signature_____**Date** _____

Print Name_____

Participation Consent & Waiver

I/we, the undersigned, do hereby agree to participate in the programming of The Bridge Adult Day Center, a program of The Bridge Alzheimer's & Dementia Resource Center.

I/we, the undersigned, do hereby expressly remiss, release, and forever discharge The Bridge Alzheimer's & Dementia Resource Center and all of its administrators, other employees, acting officially or otherwise, from any and all claims, demands, actions, or causes of actions, on account of death, or on account of injury to the undersigned, my/our heirs or assigns, which may occur as a result from said services and duties to be performed by the Adult Day Center, a program of The Bridge Alzheimer's & Dementia Resource Center.

I/we understand that The Bridge Adult Day Center, a program of The Bridge Alzheimer's & Dementia Resource Center, will re-evaluate clients every 3 months or as needed to determine their ability to participate in the programming provided at the Adult Day Center.

I understand that my participation in The Bridge Adult Day Center, a program of The Bridge Alzheimer's & Dementia Resource Center, will be DISCONTINUED if my circumstances change.

Client/Legal Guardian Signature **Date**

Print Name **Date**

The Bridge Alzheimer's & Dementia **Date**
Executive Director or Adult Day Center Administrator

Photography/Video Release Form

Date: _____

Client Name: _____

I hereby give The Bridge Adult Day Center, a program of The Bridge Alzheimer's & Dementia Resource Center, it's nominees, agents and assigns, my free and unlimited consent and permission, waiving all claims for any compensation by reason thereof or for damages by reason thereof, to use, publish/broadcast, republish/rebroadcast or exhibit in the furtherance of its work, with or without identification of me by name, the photograph/video below:

The Bridge Alzheimer's & Dementia Resource Center and the Adult Day Center Photography
To disseminate statements referring to me in conjunction therewith if The Bridge Alzheimer's & Dementia Resource Center so desires to authorize any media, company or organization to use, publish/broadcast or exhibit said photograph/video with or without identification of me by name and to publish/broadcast or disseminate statements referring to me in conjunction therewith in the promotion of The Bridge Alzheimer's & Dementia Resource Center and any of its fundraising campaigns or any of its clients.

_____
Signature

Name:_____
(Please print)

Address: _____

Phone: _____
Work/Home Cell

If the individual photographed/videotaped is a minor (under 18 years of age), a parent or legal guardian should sign the following:

I hereby consent and agree, individually and as a parent or legal guardian of _____

(a minor) to all the terms and provisions stated above.

Witness my signature this _____ day of _____ the year _____.

_____
Signature

Relationship to minor:_____

Address/Phone(s):_____

Consent for Emergency Medical Care

In the event of an emergency, the center will call 911 first. After 911 is called, the family member will be contacted.

I hereby grant permission to the staff of The Bridge Adult Day Center to obtain emergency medical care for _____ if needed. I understand that, in case of emergency, the participant will be transported by ambulance to the nearest medical facility providing emergency care and treatment. I also understand the cost of emergency medical care is the responsibility of the participant/ responsible party.

Emergency Contact_____

Phone_____

Cell Phone_____

Alternate Emergency Contact_____

Phone_____

Cell Phone_____

When possible, I would like participant to be transported to: _____

_____

Signature of Participant or Authorized Representative Date

_____

Witness/ Staff Signature Date

THE BRIDGE Alzheimer's RESOURCE CENTER & Dementia

Medication List

Date of record_____

Name_____

Emergency Contact_____

Phone_____

List Prescription and Over the Counter Medications	Dosage	Frequency

AUTHORITY TO RECEIVE AND RELEASE FOR TRANSPORTATION

I, _____, Guardian of _____hereby authorize _____ to transport and drop off _____ to The Bridge Alzheimer's & Dementia Resource Center- The Bridge Adult Day Center on designated respite days and authorize The Bridge to release _____ back to same transport. I understand that The Bridge is not responsible for any acts or omissions related to the transportation of _____, including but not limited to, accidents occurring during the loading and unloading of the passenger, even if such events occur on The Bridge Alzheimer's & Dementia Resource Center property. I agree to release The Bridge Alzheimer's & Dementia Resource Center, its volunteers, employees, directors, and officers and will hold The Bridge Alzheimer's & Dementia Resource Center harmless from any liability which might arise from incidents or injuries that occur.

Caregiver Signature_____Date _____

Print Name_____