TIME TOGETHER

ADULT DAY PROGRAM

Island Senior Resources

www.senior-resources.org/timetogether

Serving our Whidbey Island Community Since 1997

3 Steps to receive service

1. Arrange to visit the program with your family member. A four hour complimentary visit is required. (10am—2pm).

2. Fill out application and return to Director.

3. Request regular attendance days.

Application updated 03/23/2017

Island Senior Resources

Participant Name _____

Information for Families and Caregivers

Welcome to Time Together Adult Day Service! Our goal is to provide the best possible care for your loved one in a warm, friendly and safe environment. Our Staff and Volunteers are dedicated to this mission and recognize the privilege of serving you and your loved ones.

Some things we think you will find helpful to know:

St Augustine's in-the Woods (Freeland): Program days/hours are Monday, Tuesday, Wednesday and Friday 10am—2pm with extended hours by appointment. Office: 8:30 am to 4:00 pm.

Oak Harbor Senior Center—The Modular Building (Oak Harbor): Mondays, & Wednesdays 10am —2pm.

Service Rate: $18:75 per hour, minimum of 4 hours $75.00 per program day. A reduced rate Sliding Scale fee may be available to qualifying persons. See enclosed application. Respite and COPES funds are available for qualified persons. Contact Adult & Disability Resources for help. 360-321-1600 ex: 2. Time Together ADS is also contracted with DDA, you can contact your case manager to access support.

Billing: You will be billed on the first of each month for the previous months attendance. If your loved one is unable to attend a regularly scheduled day please give a minimum of 48 hours notice. In the event of sickness please call by 8am on your scheduled day. You will be charged for not attending on your scheduled days unless you give the required notice.

Discharge from Program: Please inform Director as soon as possible if you plan to stop attending Time Together.

Transportation: If you need transportation, Island Para-Transit provides service to and from Time Together if you are within their service area. Arrangements are made by the caregiver by calling 360-321-6688 or 678-7771. There is often a two to three week delay before service is available.

Meals: Provided by Island Senior Resources, Meals on Wheels program and is included in the daily fee. These meals are modifiable to accommodate diabetic or gluten-free diets.

Medications: If your loved one needs to have medication while at the Center, package the medication in a container with secure lid and labeled with the five 'R's: Right Name, Right Drug, Right Dosage, Right Time and Right Route (oral, under tongue, etc.). We will keep the medication in a locked box and bring it to your loved one at the correct time. We cannot actually administer the medication within our level of care, but we can assist with the cap, a glass of water, etc.

Bathroom Assistance: We are able to assist your loved one with most toileting needs including incontinence products, garments, hand-washing and stand-by assistance when transferring from a wheelchair to the toilet and back. You are welcome to keep a bag of extra clothing and supplies here for your loved one if that is appropriate. We are not able to lift people, nor do two-person transfers at this time.

Center Closures: We know closing the program produces a hardship on caregivers and their participants and make every effort to avoid cancellations. On occasion it may be necessary for the safety and welfare of caregivers, participants and staff to cancel the program that day. You will be notified by 8:15 a.m. Examples are:

- Inclement Weather - i.e. high winds, power loss, snow, freezing rain, etc.
- Para-transit services are cancelled due to poor driving conditions
- Two or more Staff members have a contagious illness

Emergencies In the event of an emergency (storm, earthquake, etc.) during Time Together Adult Day Service hours, we will have on hand the emergency contact numbers for all Time Together participants. This will include emergency contacts off-island and out of the area in case Island phone system is down. In the event that local numbers cannot be contacted, Emergency Personnel and participant families will communicate through the out of area contact.

Infection Control: Our services are conducted in a congregate setting with a goal of increasing interaction. With increased interaction comes the potential risk of spreading germs and infection. Staff, Volunteers and participants who have the following symptoms should stay at home so others do not become ill. They are:

Continual sneezing, coughing, or runny nose
Sore Throat - especially if associated with fever or swollen glands
Fever - especially if fever has been present in the last 12 hours
Diarrhea - especially if within the past 24 ours and accompanied by fever
Vomiting - especially if within the past 24 ours and accompanied by fever
Rash - body rash not associated with heat or allergic reactions, especially with fever and itching
Eyes - thick mucus or pus draining from the eye, or known “pink-eye”

Please, if you think your loved one is coming down with something, do not bring him or her to Time Together. Participants who appear to be ill, have a temperature, are coughing and sneezing will be isolated in a quiet comfortable room and caregivers will be notified for immediate pick up.

Contact Us: We welcome all questions and are glad to help in any way we can with your needs. We are available Monday through Friday from 8:30 a.m. to 4:00 at 360-321-1623. You may also contact us via email - mel@islandseniorservices.org We look forward to hearing from you!

Policy of Non-Discrimination: Time Together Adult Day Service provides services and employment on a non-discrimination basis and complies with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973 and the Title VI of the Civil Rights Act of 1964.

Disclosing Information to Third Parties: It is the policy of Time Together Adult Day Service not to disclose participant information to third parties, unless we have express signed permission from the participant and/or caregiver. If we do not receive permission, we will direct all inquiries to the responsible parties.

State and Federal Compliance:
Island Senior Resources, a non-profit agency, provides services and employment on a nondiscriminatory basis, and complies with the American Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973 and Title VI of the Civil Rights Act of 1964.

Fees charged for services do not cover the costs of providing adult day services. Donations are always welcome and appreciated, and will provide client scholarships, greater activity possibilities, such as outings, necessary equipment and if specified, education. We are a non-profit agency, your donation is tax deductible.

Island Senior Resources

Participant Name _____

HOLIDAYS, COLD AND FLU AND EMERGENCY INFORMATION

Senior Center/Time Together Holiday Closures

Please mark these on your calendar

New Years Day
Martin Luther King Day
President's Day
Memorial Day
Independence Day
Labor Day
Veteran's Day
Thanksgiving Day
Thanksgiving
Christmas Day
New Year's Day

Cold and Flu Season

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Fever - especially if fever has been present in the last 12 hours
Diarrhea - especially if within the past 24 ours and accompanied by fever
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Emergencies

In the event of an emergency (storm, earthquake, etc.) during Together Adult Day Service hours, we will have on hand the emergency contact numbers for all Time Together participants. This will include emergency contacts off-island and out of the area in case Island phone system is down. In the event that local numbers cannot be contacted, Emergency Personnel and participant families will communicate through the out of area contacts.

Island Senior Resources

Participant Name _____

EMERGENCY INFORMATION

Client Name:_____ DOB:_____

Address:_____

_____

Caregiver:_____ Relationship:_____

Phone: HM_____ WK_____ Cellular_____

_____

Physician:_____ Phone:_____

Specialist:_____ Phone:_____

_____

CODE STATUS:_____ POLST ON FILE? Yes_____ No_____

ALLERGIES:_____
REACTIONS:_____

Hospital Preference ____ Whidbey General Hospital ____ Island Hospital, Anacortes
____ Other_____

_____

Emergency Contacts—Out of Area Consent

In the event of an emergency and Island Phone System is not working adequately, please supply out of area contacts. In the event that contact is not occurring locally, we will convey information regarding your loved one to your out of area contacts.

Out of Area Contact _____

Relationship _____ Phone Number _____

Out of Area Contact 2 _____

Relationship _____ Phone Number _____

I request and authorize Time Together Adult Day Services to release information regarding my loved one's medical condition, including medications, to Emergency Management Services in the event of an emergency or disaster. I request and authorize Time Together ADS to inform my out of area contact about the condition of my loved one in the event that local telephone service is interrupted in the event of emergency or disaster.

I have read the information above and give my permission.

_____ _____

Spouse/POA/Guardian/Caregiver Date

Island Senior Resources

Participant Name _____

Date _____ **APPLICATION** **Start Date** _____

Name:_____ **Birth Date**:_____

Address:_____

Caregiver 1_____ **Relationship**:_____

Phones:
Home_____ **Work**_____ **Cell**_____

Email: _____

Caregiver 2 _____**Relationship**:_____

Home_____ **Work**_____ **Cell**_____

Email: _____

Physician Information

Primary Physician:_____ **Phone**:_____

Address:_____

Other Practitioners:_____ **Phone**:_____

_____ **Phone** _____

Participant Information:

Diagnosis/Challenges _____

_____

Special meal request:_____

Email: _____

_____

Caregiver Information - What are your greatest challenges and what is your support system?

_____

_____

_____

Island Senior Resources

Participant Name _____

Health History and Assessment Date _____

Date of Birth_____ Social Security #_____

Wears Medi-Alert bracelet or necklace? Yes_____ No_____ What is listed on it? _____

_____

Diagnosis/Date

Medications

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Medication/Allergies/Reactions

_____

_____

Able to self medicate? Yes_____ No_____ Requires supervision of meds? Yes_____ No_____

Take meds with food? Yes_____ No_____ Meds crushed? Yes_____ No_____

Vitamins/Supplements

_____ _____ _____

_____ _____ _____

Bladder and Bowel

____Independent and no incontinence

____Incontinent: ____ Bladder____ Frequency: ____ often ____ occasionally ____ rarely

____Incontinent ____ Bowel ____ Frequency ____ often ____ occasionally ____ rarely

Incontinence products used: ____Briefs with tabs ____ Pull-ups ____Underpants liners ____ Catheter

Bladder and Bowel

____ Needs reminding to use restroom ____ Direct to restroom and assure return ____ Assist in Restroom

Specific assistance needed (changing clothes, pads, wiping, etc.) _____

_____

_____

Ambulation and Physical Activity

_____Walk independently ____Assistance needed ____arm ____cane ____walker ____wheelchair

Assistance: Instructions/Limitations _____

_____

Exercise at home ____yes ____no Type _____

Restrictions _____

Physician Recommendations _____

Grooming and Hygiene

Task	Independent	With Assistance	Dependent
Wash hands and face			
Shower or bathe			
Shave - electric or blade			
Brush Teeth/Dentures			
Own teeth___ Upper Plate___ Lower Plate___ Partials ___			
Nail Care: Hands			
Feet			

Eating and Drinking

Task	Independent	With Assistance	Dependent
Choking problem? Yes_____ No_____			
If yes, list treatment for choking problem:			
Cutting food			
Holding utensils			

Food Allergies _____

Diet: ____Diabetic ____Low-Salt ____Low-fat ____Gluten-free Other _____

Vision, Hearing and Communication

Adequate vision **with out** glasses? Yes_____ No_____	Wears hearing aides: R_____ L_____ Has but won't wear _____
Adequate vision **with** glasses? Yes_____ No_____	Hearing loss due to:
Wears glasses all the time? Yes_____ No_____	Adequate hearing **without** hearing aides? Yes_____ No_____
Wears reading glasses? Yes_____ No_____	Adequate hearing **with** hearing aides? Yes_____ No_____
Speech: Clear_____ Unclear_____ Non-speaking____	Comprehends English? Yes_____ No_____
Able to make needs known? Yes_____ No_____	Bilingual? Other languages spoken:
How needs are made known:	Comprehends verbal cues? Yes_____ No_____
Can read and/or write?_____	List non-verbal cues used:

Check if you have CURRENTLY or a HISTORY of

Nervous System			Cardiovascular System			Comments
Epilepsy/convulsions			Chest pain/Angina			
Migraine or frequent headaches			Use Nitro ____yes ____no			
Fainting Spells			Fast pulse			
Dizziness			Slow pulse			
Paralysis ____Left ____Right			Palpitations/Fluttering Pulse			
Numbness/Loss of Sensation			Pacemaker			
MS or neurological disease			Vascular disease/clogged arteries			
Respiratory System			Bypass			
Pneumonia			Valve Replacement			
Hay Fever/Seasonal Allergies			Heart Attack/Myocardial Infarction			
Chronic or frequent cough			Congestive Heart Failure			
Emphysema/COPD			Other			
Shortness of breath			Swelling of Hands and/or feet			
Do you smoke?			Varicose veins			
Used to smoke?			Extreme Tiredness/Fatigue			
How many years did you smoke?						
How long since you quit?						
Sinusitis (chronic or otherwise)						

Additional Information:

Check if you have CURRENTLY or a HISTORY of - Use Comments column to explain if needed

Genitourinary System			Vertebral Fractures			**Comments**
Difficulty urinating			Osteoporosis			
Prostate problems			Other skeletal disorders			
Pain when urinating			Allergies—Non Food or Drug			
Urinary incontinence			What? (bee stings, etc.)			
Urinary tract infection			**Immunizations**			
Bladder infection			Tetanus shot within last 5 years			
Abnormal thirst			Flu shot each year? This year?			
Other male or female issues			Pneumonia vaccine– when?			
Kidney Disease/Surgery			TB test When? Results?			
Gastrointestinal System			If yes, successfully treated?			
Bowel/Intestinal Disease/Surgery			Other immunizations			
Constipation			**Mobility**			
Diarrhea			Walks—what distance			
Bowel Incontinence			Can stand, bearing own weight			
Polyps/hemorrhoids			Needs assistance to stand			
Fiber Therapy			Needs steadying arm to walk			
Laxative/Stool Softener use			Balance: ___Good ___Fair ___Poor			
Musculoskeletal System			Falls: ___No ____#in last month			
Bursitis / Arthritis (circle one)			Any falls require medical care			
Where?			Any falls require hospitalization			
Muscle Weakness			List injury			
Where?			Has doctor prescribed restrictions			
Muscle Pain			or limitations on activity			
Where			Describe			
Difficulty/loss of control of muscles						
Loss of range of motion of limbs						
Herniated Discs						

Additional Information:

Island Senior Resources

Participant Name _____

SOCIAL ASSESSMENT

Name by which he/she likes to be called _____

Date of Birth_____ Birthplace_____

Religious Preference_____ Active: ___Yes ___No ___ Occasionally
Registered Voter: ___Yes ___ No Active: ___Yes ___ No
Military Veteran: ___Yes ___ No Branch_____ Years Served_____
Military Experience/Honors/Rank/Where Served _____
_____
Former Occupation(s): _____
_____
Year Retired_____ Last Job Worked_____

Spouse_____ Year Married_____ Widow(er) Year_____
Marriage Anniversary _____ Spouse/Caregiver Birthday _____
Children names/Locations_____
_____
Step-children Names/Locations_____
_____
Grandchildren Names/Locations_____
_____
Schools Attended: Elementary _____ Jr High _____
High School _____University/Technical _____
_____Degree(s) _____
What does a typical day at home look like?

Favorite	Current	Past	Major City/States Of Resident	Significant Travel States/Countries
Hobbies				
Activities				
Food				
Type of Music				
Watch/Play Sports				

ACTIVITIES ASSESSMENT

Please check the interests/activities that your loved one enjoys now, those enjoyed in the past and those that were never enjoyed. This will help us in initiating conversation and providing engaging experiences and activities.

Activity	Enjoys Now	Once Enjoyed	Never Enjoyed	Additional info about what enjoyed now or in past
Day Trips				
Eating Out				
Visiting with Family				
Television				
Reading				
Walking / Exercise				
Dogs / Cats / Horses / Other				
Crafts				
Knitting / Crocheting				
Handicraft / Sewing				
Painting				
Playing cards (what games?)				
Games (board, physical games, etc)				
Word puzzles, crossword, etc.				
Travel				
Parties				
Clubs / Committees				
Cooking / Baking				
Camping				
Wood crafting				
Fixing things/home repair or remodel				
Movies				
Live Theater				
Dancing				
Opera / Symphony / Ballet				
Gardening				
Volunteering				
Church / Choir / Bible Study				

Additional Information—jobs/tasks around the house, types of puttering, projects enjoyed or still enjoying, etc. The more you can tell us, the better!

Island Senior Resources

Participant Name _____

CONSENT TO MEDICAL CARE AND TREATMENT

I hereby give permission for my loved one (listed below) to be given emergency treatment to include first aid and CPR by a qualified day care staff member at Time Together Adult Day Service.

If my loved one has a POLST form on file with Time Together Adult Day Services, signed by a Physician, I understand that Time Together Adult Day Services Staff will give this information to Emergency Medical Technicians staff and will follow the directions given by EMT. Time Together staff are required to administer CPR unless directed by EMT.

I also give my permission for transportation via ambulance or aid car to an emergency center for treatment. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed by a licensed physician or hospital when deemed **immediately necessary** or **advisable** by the physician to safeguard his/her health when I cannot be contacted. I waive my right of informed consent to such treatment.

Participant Name _____

_____ _____

Spouse/POA/Guardian/Caregiver Signature Date

Island Senior Resources

Participant Name _____

CARDIOPULMONARY RESUSCITATION POLICY (CPR)

Time Together Adult Day Service seeks to honor the wishes of our program participants and/or their guardians regarding CPR procedures.

As a social-model adult day center, we are legally required to administer CPR to every participant while at the program unless they have a “POLST” form on file. The “POLST” (Physician orders for life-sustaining treatment paradigm) form is a directive instructing medical personnel to abstain from administering CPR. This is in addition to a person’s “Living Will”, or “Advanced Directive.”

The “POLST” form can be obtained through physician. The form must be completed by the physician and the family. It will not be honored unless signed by the physician. If you have any questions, please contact Adult Day Services at Time Together 360-321-1623.

Your signature below does not imply a decision for or against CPR, but only affirms you have read and understand the policy of this agency regarding CPR.

I have read and understand the CPR Policy

_____ _____

Spouse/POA/Guardian/Caregiver Date

Island Senior Resources

Participant Name _____

Financial Agreement of Understanding

I understand that as the family member/guardian, it is my responsibility to notify Time Together Adult Day Services if my loved one will not be attending or if any difficulties, or changes in health status occurs.

- I understand that the rate is $18.75 per hour with a minimum of 4 hours ($75.00) per program day. I understand that I will be billed for days I have reserved unless I give a minimum of 48 hours notice, or in the case of sickness please call before 8:00am on the day. I will be billed by mail during the first week of the month following service. All payments are to be clearly marked with: Time Together, in the subject line. Participant accounts must be paid in full and received no later than the last day of the billing month. Credit cards can be used to pay for services by calling
  Director at 360-321-1623.

- **Sliding Scale Clients**
  I understand that I may apply to be considered for a reduced rate using the Time Together Sliding Scale application included in this packet. In order to be considered I must complete the Sliding scale application included in this packet.

- **Respite Clients Only:**
  It is my responsibility to be in contact with my Adult & Disability Case Manager to determine eligibility for coverage. I understand Respite clients service hours are billed directly to Northwest Regional Council. I am responsible for the percentage Respite does not cover (as explained by your case manager) and for any additional days used which are not covered by Respite. I will receive a statement from Adult Day Services in the first week of each month.

- **COPES Clients Only:**
  I understand that COPES clients fees for service will be billed directly to DSHS. I will not receive a bill.

BILLS SENT TO: _____

ADDRESS _____

_____

I have read and been given a copy of Financial Agreement of Understanding.

_____ _____

Spouse/POA/Guardian/Caregiver Date

TIME TOGETHER
ADULT DAY PROGRAM

Application for Sliding Scale Fees

Participant name _____ Caregiver Name _____

Date _____ Completed By _____

This form is optional. Family Caregivers who do not complete the form will be charged the full hourly rate of $18.75 (minimum of 4 hours, **$75**). If you wish to apply for sliding scale fees, complete the following for the participant and his or her household. Please include a copy of the most recent income tax returns for each person in the household.
If you choose not to apply for sliding scale please indicate in space here provided.

I _____choose not to apply for the sliding scale fee.

Signature_____ Date _____

……

(Head of Household)
Applicant S. S. # _____ D/O/B_____ Sex___ Race_____Ethnicity _____

Family size: _____ # Adults _____ # Children _____

TIME TOGETHER

ADULT DAY PROGRAM

Application for Sliding Scale Fees—Income

Please write the name of each household member and their yearly taxable income.

Name of Family member	Yearly Taxable income
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
TOTAL	$_____

I certify that the information contained in this form is accurate to the best of my knowledge.

Caregiver/ responsible party signature _____ Date _____

……

Office Use Only

Applicant is Eligible. _____ Applicant is Ineligible. _____

Scale:	$41.73 ($10.43)	$45 ($11.25)	$50 ($12.50)	$55 ($13.75)
	$60 ($15.00)	$65 ($16.25)	$70 ($17.50)	$75 ($18.75)

TIME TOGETHER SLIDING SCALE

	$ 39.25	$ 45.00	$ 50.00	$ 55.00	$ 60.00	$ 65.00	$ 70.00	$ 75.00
Household Size	Federal Poverty Level	Sliding Scale Income						
1	$ 11,880.00	$ 13,620.38	$ 15,133.76	$ 16,647.13	$ 18,160.51	$ 19,673.89	$ 21,187.26	$ 22,700.64
2	$ 16,020.00	$ 18,366.88	$ 20,407.64	$ 22,448.41	$ 24,489.17	$ 26,529.94	$ 28,570.70	$ 30,611.46
3	$ 20,160.00	$ 23,113.38	$ 25,681.53	$ 28,249.68	$ 30,817.83	$ 33,385.99	$ 35,954.14	$ 38,522.29
4	$ 24,300.00	$ 27,859.87	$ 30,955.41	$ 34,050.96	$ 37,146.50	$ 40,242.04	$ 43,337.58	$ 46,433.12
5	$ 28,440.00	$ 32,606.37	$ 36,229.30	$ 39,852.23	$ 43,475.16	$ 47,098.09	$ 50,721.02	$ 54,343.95
6	$ 32,580.00	$ 37,352.87	$ 41,503.18	$ 45,653.50	$ 49,803.82	$ 53,954.14	$ 58,104.46	$ 62,254.78
7	$ 36,730.00	$ 42,110.83	$ 46,789.81	$ 51,468.79	$ 56,147.77	$ 60,826.75	$ 65,505.73	$ 70,184.71
8	$ 40,890.00	$ 46,880.25	$ 52,089.17	$ 57,298.09	$ 62,507.01	$ 67,715.92	$ 72,924.84	$ 78,133.76

Per hour	$10.43	$11.25	$12.50	$13.75	$15.00	$16.25	$17.50	$18.75

Island Senior Resources

Participant Name _____

Financial Agreement of Understanding

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- I will notify Time Together as soon as possible if there are going to be changes in my loved one's schedule, or if I intend to terminate services. A two week notice is requested to terminate services.

- **Sliding Scale Clients**
  I understand that I may apply to be considered for a reduced rate using the Time Together Sliding Scale application included in this packet. In order to be considered I must complete the Sliding scale application included in this packet.

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  It is my responsibility to be in contact with my Adult &Disability Case Manager to determine eligibility for coverage. I understand Respite clients service hours are billed directly to Northwest Regional Council. I am responsible for the percentage Respite does not cover (as explained by your case manager) and for any additional days used which are not covered by Respite. I will receive a statement from Adult Day Services in the first week of each month.

- **COPES Clients Only:**
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CLIENT COPY

Island Senior Resources

Participant Name _____

POLICY/PROCEDURE FOR CRITICAL WANDERING
Caregiver/Family Copy

Definition: Critical Wandering: Anyone with dementia or other cognitive impairment who wanders away from supervised care, a controlled environment, or cannot be located.

1) The Lead Staff person (LS) will make all necessary measures to ensure the other Participants are supervised adequately (kept safe) while available volunteers and Staff begin an area search on foot and/or in vehicle.

2) a. The LS will call 911/EMS, giving a description of the Participant and clothing, how long they have been missing, and their medical condition.
   b. The LS will notify Island Transit 360-678-7771
   c. The LS will then call the family/caregiver to report the incident and steps being taken to recover the Participant.
   d. If the Participant is not recovered within 30 minutes, the LS will notify the local radio station, KWDB 360-675-7320
   e. The LS will pull the chart with the Participant's picture and have that ready for EMS and other searchers to view.

3) The LS shall remain available by phone until such time as the Participant is located. Also the LS will make notation of who is called and the time they are called.

4) The LS and involved Staff will fill out an incident report, to be completed no later than closing the following day

5) The Adult Day Service Director and/or LS will follow up with the family in the workweek following the incident to report on continued steps taken to prevent further critical wandering incidents.

6) The Adult Day Service Director and LS will hold a Staff Meeting within five working days to review the incident, our system in place, Staff responsibilities and how to prevent a recurrence of critical wandering incidents.

7) All Participants who are critical wanderers will be evaluated on a continuous basis for appropriateness in the Program and Director will discuss with the family/caregiver. A Participant will be discharged from the Program when his/her critical wandering is so excessive it has become disruptive to the other participants and/or the Adult Day Service Director determines the Participant is beyond the Program's ability to keep him/her safe.

Island Senior Resources

Participant Name _____

Wandering Policy/Procedure—Signature Sheet

I have received a copy of, and have read, the Policy/Procedure for Wandering. I understand that the Time Together Adult Day Service facility has three exits that must remain unlocked in compliance with the Fire Code. I understand that although Time Together staffs adequately for participants present each day, there is a risk that my loved one could wander away from the Time Together facility undetected. I also understand that due to the reasons that bring people to need adult day services, my loved one has the potential to begin wandering behavior at any time even if there has been no previous history of wandering.

I understand that the Director of Time Together Adult Day Services is always assessing the participants for behavior changes, disruptive behavior/dangerous behavior, etc. and will contact me to discuss all changes.

I have read and been given a copy of the Wandering Policy/Procedure.

_____ _____

Spouse/POA/Guardian/Caregiver Date

Island Senior Resources

Participant Name _____

STATEMENT OF RIGHTS

Caregiver/Family Copy

All persons, in attendance at Time Together Adult Day Services, whether socially isolated, yet quite healthy and those suffering from Alzheimer's Disease and/or other debilitating conditions are endowed with human rights/and those rights are not lost by decree of a condition or diagnosis. We choose to support their remaining capacities and enhance their quality of life by adopting the standards set forth in the following: ***Statement of Rights of Adult Day Services Participants***, developed by the National Council on Aging.

- The right to be treated as an adult, with consideration, respect, and dignity, including privacy in treatment and in care for personal needs.

- The right to participate in a program of services and activities designed to encourage independence, learning, growth, and awareness of constructive ways to develop one's interests and talents.

- The right to self-determination within the day services setting, including the opportunity to:
  *Participate in developing one's plan for services and any changes therein,
  *Decide whether or not to participate in any given activity,
  *Be involved to the extent possible in program planning and operation,
  *Refuse treatment and be informed of the consequences of refusal,
  *End participation in the adult day care center at any time.

- The right to be cared about in an atmosphere of sincere interest and concern in which needed support and services are provided.

- The right to a safe, secure, and clean environment.

- The right to confidentiality and the requirement for written consent for release of information to persons not authorized under law to receive it.

- The right to voice grievances without discrimination or reprisal with respect to care or treatment that is (or is not) provided.

- The right to be fully informed, as evidenced by the participant's written acknowledgment of these rights, or all rules and regulations regarding participant conduct and responsibilities.

- The right to be free from harm, including unnecessary physical or chemical restraint, isolation, excessive medication, abuse, or neglect.

- The right to be fully informed at the time of acceptance into the program, of services and activities available and related charges.

- The right to communicate with others and be understood by them to the extent of the participant's capability.

Island Senior Resources

Participant Name _____

STATEMENT OF RIGHTS

All persons, in attendance at Time Together Adult Day Services, whether socially isolated, yet quite healthy and those suffering from Alzheimer's Disease and/or other debilitating conditions are endowed with human rights/and those rights are not lost by decree of a condition or diagnosis. We choose to support their remaining capacities and enhance their quality of life by adopting the standards set forth in the following: ***Statement of Rights of Adult Day Services Participants***, developed by the National Council on Aging.

- The right to be treated as an adult, with consideration, respect, and dignity, including privacy in treatment and in care for personal needs.
- The right to participate in a program of services and activities designed to encourage independence, learning, growth, and awareness of constructive ways to develop one's interests and talents.
- The right to self-determination within the day services setting, including the opportunity to:
  - *Participate in developing one's plan for services and any changes therein,
  - *Decide whether or not to participate in any given activity,
  - *Be involved to the extent possible in program planning and operation,
  - *Refuse treatment and be informed of the consequences of refusal,
  - *End participation in the adult day care center at any time.
- The right to be cared about in an atmosphere of sincere interest and concern in which needed support and services are provided.
- The right to a safe, secure, and clean environment.
- The right to confidentiality and the requirement for written consent for release of information to persons not authorized under law to receive it.
- The right to voice grievances without discrimination or reprisal with respect to care or treatment that is (or is not) provided.
- The right to be fully informed, as evidenced by the participant's written acknowledgment of these rights, or all rules and regulations regarding participant conduct and responsibilities.
- The right to be free from harm, including unnecessary physical or chemical restraint, isolation, excessive medication, abuse, or neglect.
- The right to be fully informed at the time of acceptance into the program, of services and activities available and related charges.
- The right to communicate with others and be understood by them to the extent of the participant's capability.

I have read and been given a copy of the Statement of Rights.

_____ _____

Spouse/POA/Guardian/Caregiver Date

Island Senior Resources

TIME TOGETHER
ADULT DAY PROGRAM

Island Senior Resources
5518 Woodard
Freeland, WA 98249

Re: Permission to use photographs, quotes or videos.

I, _____, grant the following rights to Island Senior Resources, it's representatives and employees.

1. to take photographs and/ or video of me and my property
2. To use quotes of statements I have said or written
3. To use and publish the same in print and/ or electronically with or without my name attached.

I agree that Island Senior Resources will be the copyright holder of any photographs or video they or their representatives record.

I agree that Island Senior Resources may use such photographs, video or quotes for any lawful purpose, including for example such purposes as publicity, illustration, advertising, fundraising, and Web content.

I have read and understand the above:

Signature_____

Printed name_____

Organization Name (if applicable)_____

Address_____

Date_____

Signature of the person of responsibility in the event the person being photographed, video recorded or quoted is unable to sign_____

Signature of parent or guardian_____(if under age 18)

TIME TOGETHER

ADULT DAY PROGRAM

Please supply 2 identical head and shoulder photographs of the person who will be attending Time Together.

☐

Please tick the box to verify that you have supplied the requested photo’s.

Signed_____Date_____

Island Senior Resources

Participant Name _____

GRIEVANCE PROCEDURE

If you have a complaint regarding the Time Together Adult Day Services Program delivery, call 360-321-1600 or 360-678-337 and Mel Watson, ADS Director, will respond to your complaint.

If you are still not satisfied, you have the right to a hearing before the service provider regarding eligibility service delivery and service satisfaction issues. All client grievances must be submitted in writing to Island Senior Resources, 14594 SR 525, Langley, WA 98260, ATTN: Cheryn Weiser, Executive Director

A hearing date shall be established within (15) days of receipt of the grievance. All parties who will participate in the hearing shall be notified in writing of the hearing date within [5] days of the hearing.

If you are still not satisfied with the results of the hearing at the service provider level, you may request an investigation by the Northwest Area Agency on Aging. Call 360-922-7861or 360-676-6749 and Angela Ross will respond to your complaint.

If you are still not satisfied, you may request a local/regional hearing, and potentially a state level hearing through the AAA.

Island Senior Resources

Participant Name _____

GRIEVANCE PROCEDURE

If you have a complaint regarding the Time Together Adult Day Services Program delivery, call 360-321-1623 and Mel Watson, ADS Director, will respond to your complaint.

If you are still not satisfied, you have the right to a hearing before the service provider regarding eligibility service delivery and service satisfaction issues. All client grievances must be submitted in writing to Island Senior Resources, 14594 SR 525, Langley, WA 98260, ATTN: Cheryn Weiser, Executive Director

A hearing date shall be established within (15) days of receipt of the grievance. All parties who will participate in the hearing shall be notified in writing of the hearing date within [5] days of the hearing.

If you are still not satisfied with the results of the hearing at the service provider level, you may request an investigation by the Northwest Area Agency on Aging. Call 360-676-6749 or 800-585-6749 and Angela Ross will respond to your complaint.

If you are still not satisfied, you may request a local/regional hearing, and potentially a state level hearing through the AAA.

I have read and been given a copy of the Grievance procedure.

_____ _____

Spouse/POA/Guardian/Caregiver Date