Our Mission

To provide resources that enhance the emotional, social, and physical well-being of seniors, adults with disabilities, and those who care for them.

Our Vision

Island Senior Resources envisions strong communities where seniors, adults with disabilities, and those who care for them are valued, heard and seen, cared for and about, afforded respect, treated with dignity, and supported to live their best life.

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1. Please call Time Together Director Mel Watson at (360) 321 1623 to arrange for you and your loved one to visit the program for Free!

2. Once you have visited the program, please fill out the information below, make a copy for your own records, and either scan a copy and send to Mel Watson at **mel@islandseniorservices.org** or deliver the original copy to:

   Mel Watson.
   Island Senior Resources
   14594 SR 525,
   Langley WA 98260

Mel will contact you once the application has been processed to discuss any details and to arrange a starting date.

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3. Please visit https://senior-resources.org/wp-content/uploads/2017/02/Time-Together-Policies-and-Procedures-Manual.pdf to read/ download or copy the policies and procedures manual for the Time Together Adult Day Program to refer to and keep with your records.

We look forward to serving you and your family!

Sign here_____ Date_____

- By signing and dating each page of this application, I give authorization to share information on this application with those named below and Emergency Medical Technicians in the event of an emergency. Please initial here_____

Participant/ Care Receiver Name:_____

Birth Date:_____

A**ddress**:_____

Meal Request. Regular ____Diabetic____ Gluten Free_____ No Meal_____ Other_____

(if No Meal or Other stated, please give details)_____

Diagnosis/Challenges and Dates

Medications List (attach additional page if not enough room. Please date additional pages)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Sign here_____ Date_____

Need medication while in program?

Yes_____ No_____ Requires supervision? Yes_____ No_____

Please give direction for medication needs during program. Participant must be able to take medication unassisted. Staff are authorized to prepare and remind participants but are not authorized to give medications.

_____

_____

_____

Social Security #_____Wears Medi-Alert bracelet or necklace? Yes___ No___
What is listed on it? _____

Caregiver or Emergency Contact 1_____Relationship:_____

Home_____ Work_____ Cell_____

Email: _____

Caregiver or Emergency Contact 2 _____Relationship:_____

Home_____ Work_____Cell_____

Email: _____

Out of Area Contact _____

Relationship _____ Phone Number _____

Out of Area Contact 2 _____

Relationship _____ Phone Number _____

Physician:_____ Phone:_____

Specialist:_____Phone:_____

POLST ON FILE? Yes_____ No_____

ALLERGIES:_____

REACTIONS:_____

Hospital Preference ____ Whidbey General Hospital ____ other_____

Sign here_____ Date_____

Bladder and Bowel

____Independent and no incontinence ____Incontinent

Please give details_____

____ Needs reminding to use restroom

____ Direct to restroom and assure return

____ Assist in Restroom

- **Regular rest room breaks are encouraged every 45 mins to 60 mins.**

Incontinence products used Yes_____ No_____

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			

Sign here_____ Date_____

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			

Vision, Hearing and Communication

Wears glasses Yes_____ No _____ **Adequate vision without** Yes ____ No ____

Additional information about vision

_____

Wears hearing aides Yes ____ No ____ **Adequate hearing without** Yes ___ No ___

Additional information about hearing

_____

Speech Clear _____ Unclear _____ Non Verbal _____

Able to make needs known Yes_____ No _____ Details_____

_____

Comprehends English Yes _____ No _____ **Bilingual** Yes_____ No _____

Sign here_____ Date_____

Current or History (Please check all that apply)

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?			Additional Information			
How long since you quit?						

Sign here_____ Date_____

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			

Sign here_____ Date_____

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						

Social Assessment

Birth place_____ **Schooling** _____

_____

Work History/ Occupations_____

Family History_____

_____

Military Veteran _____ **Details** _____

Sign here_____ Date_____

List Hobbies Past and present_____

_____

_____

_____

_____

_____

Describe a typical day at home_____

_____

_____

_____

I have downloaded or been given a hard copy of the Time Together Adult Day Services Policies and Procedures Manual and have read and understood the following.

Emergency Procedure Signed_____ Date_____

CPR Policy Signed_____ Date_____

Critical Wandering Policy Signed _____ Date_____

Grievance Policy Signed _____ Date_____

Statement of Rights Signed _____ Date_____

I have a copy for my own records _____Yes

Sign here_____ Date_____

FINANCIAL AGREEMENT

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.

Please tick the method of payment that applies to you.

_____Full fee payment ($80 per day)

_____Sliding Scale (See attached qualifying chart $45.49 - $80 per day)

Number of people in the household_____ Taxable income_____

_____Respite through the Family Caregivers Support Program

_____ Tailored Support for Older Adults (TSOA)

_____COPES

(My COPES Case Managers name is _____

Contact number _____)

_____ Developmental Disabilities Administration (DDA)

(My DDA Case Managers name is _____

Contact number _____)

_____ Lifespan Respite

_____ Scholarship Program

I understand that I will be billed for days I have reserved unless I give at least 48 hours' notice, or in the event of illness I call by 8:00am on my scheduled day. Those on respite programs will be asked to pay privately for no shows or late cancelations, unless circumstances are communicated and discussed with the Director.

I may call the Director to request and reschedule a canceled day if I choose. I will be billed by mail during the first week of the month following service. Any billing inquiries are made to ISR Finance Department. Phone: (360) 331 5722. 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

Sign here_____ Date_____

- 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.

IMPORTANT NOTES

- **Respite Clients:**

  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 ISR Finance Department in the first week of each month.

- **COPES Clients Only:**

I understand that COPES client fees for service will be billed directly to DSHS. I will not receive a bill.

PERMISSION TO SHARE INFORMATION

Time Together Adult Day Program is a service of Island Senior Resources (ISR). We strictly adhere to the HIPPA act of 1996 which provides data privacy and security previsions for safeguarding medical information. Information contained in this application will not be shared with anyone outside of the Time Together Adult Day Program staff, those named as Caregivers and Emergency contacts and EMT staff in the event of an emergency, unless there is written permission given below.

This form is intended to create ease of access for participants and family members of Time Together Adult Day Program and other ISR programs.

I give permission to share this application with Aging & Disability Resources Specialists/ Case Managers and welcome the opportunity for them to contact me to inquire about additional services that I may be eligible for.

Sign here_____ Date_____

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.

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)

Sign here_____ Date_____