Admission Packet

The mission of Gateway Adult Center is to provide a safe and friendly group care program for dependent adults during the day. The center provides a comfortable and encouraging environment with a wide variety of activities to enrich the lives of each participant. The program is designed to maintain the participant highest level of independence and well-being, and to meet the needs of frail or impaired adults over 18 years old, including those with MS, diabetes, traumatic brain injuries, Alzheimer’s, and other forms of dementia. The program provides an economical alternative that enables families to remain together longer while extending independence and offering "Gateway Adult Center" for the recipient and the caregiver.

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Other Documents to be completed.

Medical Exam form - (Please have Doctor's office complete and return to GAC) TB Test Consent form.

**Instructions**

1. The client or responsible party should fill out the forms completely.

2. Please feel free to ask for assistance. Call 903-471-8674

3. After completing the forms, return the packet to the Director of Gateway Adult Center.

4. Pay the admission/processing fee.

5. Get a physical examination and submit the report. Form is included in this packet.

6. Complete step one of the TB Test.

7. Return 48 to 72 hours later to have the test ready and recorded.

8. Bring a copy of the negative results to GAC and join the program.

9. State requires a second TB test 1 to 3 weeks later, after participant is attending GAC.

The information you provide in this packet is extremely helpful in providing the custom care plan and the most beneficial activity program for the participant. This information will be kept confidential.

**Gateway Adult Center, LLC**

310 N Fulton St

Marshall, TX 75670

Phone: 903-471-8674

Fax: 903-471-8675

Info@gatewayadultcenter.com

www.gatewayadultcenter.com

**Certifications**

Texas State License: Tx20101030866

Bureau of Health Care Quality and Compliance License: 5907ADC-1 Marshall City License: 75670

State Health Permit: WA-02-10113

ServSafe Certificate: 6964254

Gateway Adult Center Application for Enrollment

The information you provide in this form is extremely helpful in providing the custom care plan and the most beneficial activity program for the Client. Please print clearly.

Client name (the one to receive care at Gateway)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date:\_\_\_\_\_\_\_\_ Preferred name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you learn about GAC? Please circle five aspects about GAC that you feel will help the client the most.

**Enriching activities**

**Nutritious diet**

**Friendly staff**

**Wellness monitoring**

**Financial aid**

**Saturday’s manicure, pedicure**

**Limo tours**

**Peer support and friendship**

**Shower, bathing licensed nurses**

**Secure facility**

**Caregiver support holidays**

**Med reminders**

**Laughter yoga**

**Transportation**

**Incontinence management**

**Patio gardening**

**Exercise program**

**Affordable rates**

**Fall reduction haircut, color, set**

**Musical performances**

**Communication board**

 Responsible party:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical address: Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Billing address: Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_ Cellular: \_\_\_\_\_\_\_\_\_\_

Telephone number where you want to receive calls about your appointments, billing questions, or other healthcare questions: \_\_\_\_\_\_\_\_\_\_\_\_\_. Please note that we will use this number to leave messages if there is no answer.

Client Info:

Relationship to Responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical address Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_

Date of birth / / SSN\_\_\_\_\_\_\_\_\_\_\_\_\_ (required by state)

Military affiliation: Y N Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact Name Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Program attendance of at least twice a week is required for noticeable improvement.

Desired client attendance schedule (circle): M T W T F S Start Time: \_\_\_\_\_\_\_\_\_\_\_ Depart Time: \_\_\_\_\_\_\_\_\_\_

Desired mode of transportation to and from center (circle):

Family vehicle RTC ACCESS Bus

 (Ask for application packet if not already using RTC) More to Life Limo (See page 11 for fee details).

**Social History**

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information you provide in this form is extremely helpful in providing the custom care plan and the most beneficial activity program for the Client.

General Information about Client:

Married\_\_\_\_ Single\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent's names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are parents living? \_\_\_\_\_ If so, where Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Countries lived in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Travel Experience: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School and Work History**

Schools attended/Grade School, High School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degrees: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Primary Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Favorite subjects in school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attitude toward work (like/dislike): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Languages: \_\_\_\_\_\_\_\_\_\_\_\_

Does client do any writing? Y N Longhand Printing Computer Does client read? Books Y N Kinds of books: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Magazines: \_\_\_\_\_\_\_\_\_\_ Newspaper:\_\_\_\_

Personal Interests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies/interests\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreation outdoors\_\_\_\_\_\_\_\_\_\_\_\_\_ Indoors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Play any musical instruments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other skills/talents (art, typing, sports, singing, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Club/Organizations/Church (membership): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Goals and Information**

Family's impression of major strengths\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the goals of the client? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of positive reinforcement may motivate client? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any topics of discussion to be avoided? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any culturally sensitive areas we should know about? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reaction of friends and relatives since onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client's sons, daughters, grandchildren and other close relatives and close friends.

Name Nickname Relationship Age City/State Phone number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible party signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ Approximate date of onset: \_\_\_\_\_\_\_\_\_\_\_

Describe any major illness or accident in addition to primary diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personality prior to onset (outgoing, shy, social etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Personality since onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is participant bladder continent? Y N

Need help in restroom? Y N

Is participant bowel continent? Y N

Does participant wear glasses? Y N

**Reading Driving All the time**.

Does participant have hearing loss? Y N

**right ear left ear both ears**

Hearing aid? Y N **Right ear left ear both ears**

Does participant wear dentures? Y N

**Partial Complete**

Cane Walker Wheelchair (circle one)

Favorite Foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medicines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diet restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

Name of medication Reason prescribed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose and Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date begun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the personnel of GAC to remind or administer the medicine(s) listed above.

Responsible party signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Please identify any changes in the recent months relative to the following:

Impulsivity Y N

Repetitive questioning Y N

Wandering Y N

Memory loss Y N

Has client had any falls in the last three months? Y N

If yes, how many times? \_\_\_\_\_\_

Do you see any loss of balance or unsteadiness when client walks? Y N

Have you noticed any weaknesses? Y N

Does client have difficulty getting up from a chair or toilet? Y N

Can client walk 50 feet without appearing fatigued? Y N

Does the client complain of any pain? Y N

 If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gateway Adult Center Policies and Client Agreement**

**PROGRAM POLICY**

 Initial: \_\_\_\_\_\_\_

* These policies are based on respect, cooperation, confidentiality, and safety of our clients.
* Client must not require any form of restraint or sedative unless ordered by a physician.
* The client must not pose a danger to self or others. Clients engaging in disruptive behavior are subject to dismissal from the program.
* Client may be incontinent and require staff assistance with toileting. Scheduled bowel and bladder programs are arranged for clients willing to participate.
* Clients will be discharged or referred to other programs if their needs cannot be met by More to Life or if the Client or Responsible party is in violation of this agreement.
* Gateway Adult Center is a smoke-free facility.
* A change of clothes and a supply of disposables should be kept at the facility in case of an accident.
* Clients should always have proper identification with them.
* Clients are served a noon meal, meeting 1/3 of the RDA requirements and approved by a certified dietician. Additional nourishment is provided mid-morning and mid-afternoon.

The management of Gateway Adult Center agrees to exercise the best of care for its clients, however, More to Life is in no sense an insurer of the client's safety or welfare and assumes no liability as such.

The management of the More to Life program will not be responsible for any valuables or money left in the possession of participants while he or she is active in the program.

Pursuant to Title VI of the Civil Rights Act of 1961, GAC Program is nondiscriminatory. Religion, race, national origin, age, or gender will not be considered in client admission process or treatment following admission.

**MEDICATION POLICY**

Initial: \_\_\_\_\_\_\_\_\_

* Medication taken at GAC will be administered by the nurse on duty or self- administered as reminded by staff according to physician's orders. Records will be kept accordingly.
* All medications must be provided in the fully labeled containers in which they were dispensed. A secure area will be provided for the client’s medication.
* Clients are not permitted to possess medications while in the facility. The consequences of any violation of this policy will be the responsibility of the responsible party.
* Client or Responsible party is required to update the Director at Gateway Adult Center of any changes in medications or physician's orders.
* In case of Emergency Responsible party grants permission for any treatment for the Client that a physician deems necessary.

**ILLNESS POLICY**

Initial: \_\_\_\_\_\_

* Client must have a physical examination conducted by a physician, physician's assistant or
* nurse practitioner, within six months prior to admission into the GAC program. The
* updated physical along with a complete medical history and any dietary restrictions must be provided before the first attendance day.
* Client must have the first step complete of a 2-step TB test with negative results or a negative chest x-ray and must not have any of the following symptoms:
1. Has had a cough for more than 3 weeks,
2. Has a cough which is productive,
3. Has blood in the sputum,
4. Has a fever which is not associated with a cold, flu or other apparent illness,
5. Is experiencing night sweats,
6. Is experiencing unexplained weight loss, or
7. Has been in close contact with a person who has active tuberculosis.
* Client is not permitted to attend the program if they have had a fever in excess of 100°F, uncontrollable diarrhea or vomiting within the previous 48 hours.
* Responsible party agrees to notify the GAC Management immediately if Client or Caregiver are exposed to or contract a communicable disease.
* If the Client is hospitalized or absent from GAC for more than 30 days, the Responsible party must bring a written note from the doctor stating the date the Client can safely return to the program, along with any special instructions.

**FINANCIAL POLICY**

Initial: \_\_\_\_\_\_\_

* Payments are due within fifteen (15) days from the invoice date. Unpaid invoices will bear an interest rate of 1.5% per month, or the maximum allowable by law if less, from due date until paid. The responsible party will be responsible for all charges incurred at GAC including those not covered by insurance or other financial support and all costs associated with payment collection.
* The Responsible party agrees to pay $40 for every returned check.

**PRIVACY POLICY**

Initial: \_\_\_\_\_\_\_\_

* GAC (Gateway Adult Center, LLC) arranges some activities that may involve visitors to the center, which will sign confidentiality statements disclosing that they may notdiscuss or repeat any client or personal information they may see or hear while visiting MTL. Monthly calendars are posted on the bulletin board and on the MTL website for your review and appropriate planning of events.
* GAC (Gateway Adult Center, LLC) uses health information about you to provide services, to obtain payment for services, for administrative purposes, and to evaluate the quality of client care. Client health information is contained in a file that is the physical property of MTL.
* GAC (Gateway Adult Center, LLC) may use client health information to provide services to the client. For example, MTL will record information related to client service. This information is necessary for and may be transmitted to providers to determine what services the client should receive.
* GAC (Gateway Adult Center, LLC) may use and disclose client health information to others for purposes of receiving payment for services. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies the client, diagnosis, and service or supplies used in the course of service.
* GAC (Gateway Adult Center, LLC) may use and disclose health information for operational purposes. For example, client health information may be disclosed to staff members, risk or quality improvement personnel, and others to: evaluate the performance of our staff, assess the quality of our services, learn how to improve our services and determine how to continually improve the quality and effectiveness of the
* services we provide.
* Even if an individual has requested additional restrictions on uses and disclosures of health information and GAC (Gateway Adult Center, LLC) has agreed, if the individual is in need of emergency treatment and the restricted protected health information is needed to give the emergency treatment, MTL may use the restricted protected health information, or may disclose such information to a health care
* provider, to give such treatment to the individual. GAC will require that such health care provider not further use or disclose the information.
* GAC (Gateway Adult Center, LLC) may use client information to contact you about appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
* Health information may be disclosed to an individual's personal representative if the person is authorized to act on behalf of an individual, or under the law the person is an executer, administrator or other person with authority to act on behalf of an individual.
* GAC (Gateway Adult Center, LLC) may use and disclose client information as required by law. For example, GAC may disclose information for the following purposes: for judicial and administrative proceedings pursuant to legal authority, to report information related to victims of abuse, neglect or domestic violence, and to assist law enforcement officials in their law enforcement duties.
* Client health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.
* Client health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.
* GAC (Gateway Adult Center, LLC) may use client health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of health information has approved the research.
* Client health information may be disclosed to avert a serious threat to the health or safety of client or any other person pursuant to applicable law.
* Client health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.
* Client health information may be used or disclosed to comply with laws and regulations related to Workers' Compensation.
* Other uses and disclosures will be made only with your written authorization, and you may revoke the authorization except to the extent GAC has taken action in reliance on such.

**Client Health Information Rights**

You have the right to:

* Request a restriction on certain uses and disclosures of client health information; however, GAC is not required to agree to a requested restriction.
* Obtain a paper copy of the notice of information practices upon request.
* Inspect and obtain a copy of your file.
* Request that your file be amended or corrected.
* Request communications of client health information by alternative means or at alternative locations.

Receive an accounting of disclosures made of your health information.

**Complaints**

* You may complain to GAC and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

**Obligations of GAC**

GAC is required by law to:

* Maintain the privacy of protected health information.
* Provide you with this Notice of its legal duties and privacy practices with respect to client health information.
* Notify you if we are unable to agree to a requested restriction on how client information is used or disclosed.
* Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.
* GAC reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised Notices will be made available to you upon request.

**PHOTOGRAPHY POLICY**

Initial: \_\_\_\_\_\_

* The Responsible party authorizes GAC (Gateway Adult Center, LLC) to photograph, video and/or audio tape
* The Client for clinical purposes. (example: ID badge, client file and notable injuries) Initial:
* Please initial if in agreement or cross out if not.
* The Responsible party authorizes GAC (Gateway Adult Center, LLC) to photograph, video and/or audio tape the
* Client for Marketing purposes. (example: Web site, publications, advertisements) Initial: Please sign if in agreement or cross out if not.

**ADVANCE DIRECTIVE**

Place an X in the spaces that apply:

Client does not require a Power of Attorney and may sign legal documents independently.

Client has a Power of Attorney or Legal Guardian, name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client has an Advance Directive. Responsible party will provide More to Life with an original of the Advance Directive

Client does not have an Advance Directive

Responsible party would like information on how to obtain an Advance Directive.

Client does not want an Advance Directive.

Client has a DNR (Do Not Resuscitate) order.

The responsible party will provide More to Life with copies of the above Advance Directive documents.

**Level of Care**

Level 1:

* Examples of Participant's capabilities or needs:
* Eats independently. No monitoring of special diet or medications.
* Participates in group activities without special modifications or frequent intervention.
* Occasional stand-by assistance to walk or transfer safely.
* Uses toilet without assistance.

Level 2:

* Requires regular supervision and/or assistance in social or personal care activities.
* Requires frequent intervention.
* Requires assistance with ambulation, transferring, toileting or feeding.
* Requires special diet, medication, or Oxygen.

**Fee Schedule**

**Program Rates**

(no lunch) 9:00 - 4:00

7:00 - 5:30 7-1 or 12-5 7-12 or 1-5 Most Holidays &

**Full Day Half Day Plus Half Day Saturdays**

Level 1: $ 59 $ 44 $ 34 $ 59

Level 2: $ 79 $ 54 $ 44 $ 79

These per-day rates include healthy snacks and lunch except for "Half Day".

**Other Services and Fees**

Application fee $75,

TB test $28 per test.

Shower $15

Transportation one way $10, $1/mile over 10 miles. Strong referrals available for Trusted In-Home Care.

* Some individuals may have multiple conditions or specific needs which may require frequent staff.
* intervention and supervision beyond Level II. All rates will depend on the assessment performed by GAC management.
* Harmful or abusive individuals will be referred to a more appropriate facility.
* Those who attend at least twice a week have a much higher rate of success.
* Some individuals who meet income and other criteria may qualify for financial assistance.
* MTL is an approved MEDICAID and VA PROVIDER.

The responsible party understands and agrees to abide by all the GAC (Gateway Adult Center, LLC) Policies as outlined above and on the included pages.

Responsible party (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party (sign): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_MTL Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_

**Client Rights**

1. You have the right to be fully informed of all your rights and responsibilities as a client of the program.
2. You have the right to appropriate and professional care relating to your needs.
3. You have the right to be fully informed in advance about the care to be provided by the program.
4. 4You have the right to be fully informed in advance of any changes in the care that you may be receiving and to give informed consent to the provision of the amended care.
5. You have the right to participate in determining the care that you will receive and in altering the nature of the care as your need changes.
6. You have the right to voice grievances with respect to care that is provided and to expect that there will be no reprisal for the grievance expressed.
7. You have the right to expect that the information you share with the agency will be respected and held in strict confidence, to be shared only with your written consent and as it relates to the obtaining of other needed community services.
8. You have the right to expect the preservation of your privacy and respect for your property.
9. You have the right to receive a timely response to your request for service.
10. You shall be admitted for service only if the agency has the ability to provide safe and professional care at the level of intensity needed.
11. You have the right to be informed of our agency policies, charges, and costs for services.
12. If you are denied service solely on your inability to pay, you have the right to be referred elsewhere.
13. You have the right to honest, accurate information regarding the industry, agency and of the program.
14. You have the right to be fully informed about other services provided by this agency.

Initial: \_\_\_\_\_

**AUTHORIZATION TO RELEASE PATIENT INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Gateway Adult Center to disclose from the health records of:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last First Middle

DOB: / / SSN#\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ street city state zip

Covering the periods of healthcare (Date(s) of service): From (date): \_\_\_\_\_\_to (date): \_\_\_\_\_\_

For the purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if requested by the patient, simply state "at the request of the individual")

To disclose to (receiver of information):

The following information may be released: (please indicate the types of records that may be released, i.e., clinical summaries, laboratory reports, nurses' notes, or all medical records):

Check and initial all that are applicable:

I understand that this will include information relating to:

 [ ] Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection

 [ ] Behavioral health services and/or psychiatric care

 [ ] Treatment of alcohol and/or drug abuse

 [ ] Physical examination reports AFFIRMATION OF RELEASE

 [ ] TB test results

I give (provider of information) permission to release the information I have selected on this form to the individual(s) or provider(s) I have named for the purposes I have checked.

Responsible party signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relationship to client: \_\_\_\_\_\_\_\_\_\_\_Date signed: \_\_\_\_\_\_\_