James L. West Senior Day Program Enrollment Procedures

Thank you for your interest in The James L. West Senior Day Program. Our program is designed specifically for those who wish to keep their loved ones with dementia living at home. This program allows older adults with dementia to enjoy socialization, meals, and activities with friends for up to five days a week.
To complete your application for admission to our Senior Day Program we will need the following documents completed:

1. The attached completed Participant Agreement, Application, and other disclosures signed and dated by the responsible party.
2. A completed "Physician's Orders" form **with proof of recent TB test** (within the last 30 days) and signed medication orders if medications will be taken while at the Senior Day Program. This must be completed prior to scheduling an assessment.
3. Admission requires an in-person assessment with our Nurse and/or Program Director.
4. If you believe the participant's attendance may be covered by Long-term Care Insurance benefits, please contact your individual provider for eligibility and qualification instructions.

James L. West Senior Day Program
PARTICPATION AGREEMENT

This Agreement is entered into effective as of ___________________ between ____________________ ("Responsible Party"), as the duly authorized representative of ____________________ ("Participant"), and the James L. West Presbyterian Special Care JLWSDP d/b/a James L. West Senior Day Program, a Texas nonprofit corporation (the "JLWSDP") (collectively, the "Parties").

RECITALS

A. Responsible Party is the guardian, attorney-in-fact, or other duly authorized representative of Participant and has furnished the JLWSDP with written documentation, satisfactory to the JLWSDP, evidencing his/her authority to act on Participant's behalf with respect to both business and health care matters.

B. The JLWSDP is a secured day program for those living with dementia, organized under the laws of the State of Texas. The JLWSDP is operated in accordance with the applicable laws and regulations of the State of Texas.

C. The JLWSDP is operated on a nondiscriminatory basis and affords equal treatment and access to its services for all persons who are Participants without regard to race, color, religion, ancestry, national origin, sexual orientation, or gender identity. The JLWSDP's Compliance Director is the Section 504 (Handicap) Grievance Coordinator.

D. Responsible Party believes that it is in Participant's best interest to be placed in a secured environment within the JLWSDP for Participant's own safety, and hereby gives his/her consent for Participant to be placed in a secured environment within the JLWSDP.

For and in consideration of the mutual covenants expressed herein, the Parties agree as follows:

SECTION I.
OBLIGATIONS OF THE JLWSDP

A. Basic Services

The JLWSDP agrees to provide the following basic services:

- Assistance with the activities of daily living
- Breakfast, lunch and snack daily when in attendance
- Supervised social and recreational services
- Administration of medications as prescribed by a physician

Supplemental Services
In addition to the aforementioned basic services, supplemental services and items are available to Participant at an additional charge, which will be added to Participant's monthly bill. Such supplemental services and items include, but are not limited to, barber and beauty care and special medical equipment/devices/supplies not part of the routine care.

SECTION II.
TERM OF AGREEMENT AND CONDITIONS OF PARTICIPATION

A. Term
The term of this Agreement shall begin on the day of Participant's admission to the JLWSDP. The Agreement will terminate upon termination by Responsible Party or the JLWSDP in accordance with Section III.

B. Basic Service Fee
The current fee for basic services ("Basic Service Fee") is $100 per day. Basic Service Fees will be billed monthly.

C. Fees for Supplemental Services and Items
Fees for supplemental services and items will be included on Participant's monthly statements.

D. Admission Fee
There is a one-time, non-refundable admission fee of $100 which will appear on your first monthly statement.

E. Fee Adjustments
The JLWSDP is sensitive to the cost of care. However, the JLWSDP, on thirty (30) days advance notice to Responsible Party, may adjust fees from time to time to reflect increases in Participant's level of care or JLWSDP-wide rate increase. At a minimum, the rate is adjusted annually, with a 30-day notice.

F. Payment on Account

The Basic Service Fee will be billed on the 1st business day of the next month following the month attended, for the days attended. Additional fees for services incurred or supplies will be billed on this monthly invoice as well. Statements will be emailed to the Responsible Party as listed on the Application for Admission.

Payments are drafted for each account by the JLWSDP via ACH on the closest 5th business day of the month. However, payment can also be paid by personal or business check if necessary. Any account that is not paid via ACH but paid by check or with credit card will be accessed a monthly fee: $15 per check and $35 per credit card transaction.

G. Delinquent Accounts

Responsible Party understands and agrees that Participant's account shall become delinquent if not paid by the 10th of the next month. Fees not paid by the 10th will be charged an additional $3.00 per-day late fee until the balance is paid. Responsible Party understands that continuing delinquency is a ground for termination of this Agreement as specified below in Section III.

No accounts will be allowed to be delinquent more than 30 days. Services will be discontinued for any past due accounts.

If the JLWSDP incurs any attorney fees to collect unpaid balances owed by Participant, then Participant shall be liable for the JLWSDP's reasonable attorney fees and collection costs in addition to the amounts owed for services provided. Any returned checks or non-funded ACH debits will be charged a fee of $35.00 per occurrence.

SECTION III
TERMINATION OF AGREEMENT

A. Termination of Agreement by Responsible Party

Responsible Party may terminate this Agreement at any time. Concurrently with such termination, Participant shall be withdrawn from the JLWSDP. Upon the termination of this Agreement, the JLWSDP shall be paid all amounts due and owing.

B. Termination of Agreement by the JLWSDP

The JLWSDP may issue a 14-day written notice of discharge for the following reasons:

1. In the sole opinion of the JLWSDP, Participant's needs cannot reasonably and adequately be met by the JLWSDP;
2. Participant is delinquent in the payment of fees and expenses;
3. The JLWSDP ceases to operate.

If the JLWSDP terminates the Agreement and discharges Participant under this Section, then Responsible Party will cooperate with the JLWSDP to facilitate Participant's discharge.

C. Immediate Termination of Agreement by the JLWSDP

The JLWSDP may terminate this Agreement and discharge Participant at any time with no advance written notice, when any of the following conditions or situations exist:

1. In the sole opinion of the JLWSDP, immediate transfer or discharge is medically necessary to adequately meet Participant's needs; or

2. In the sole opinion of the JLWSDP, Participant presents a threat to the health and safety of himself or herself or other individuals working in, employed by, visiting at, or residing in the JLWSDP.

If the JLWSDP terminates the Agreement and discharges Participant under this Section, then Responsible Party will cooperate with the JLWSDP to facilitate Participant's discharge.

SECTION V
INDEPENDENT PROVIDERS AND PRIVATE DUTY PERSONNEL

Independent Providers

Responsible Party hereby acknowledges and agrees that physicians, dentists, and therapists, including those whose services are arranged for by the JLWSDP, are independent contractors and are not employees or agents of the JLWSDP. The JLWSDP shall not be responsible for their acts or omissions or for any consequences stemming from following physician, dentist, or therapist orders. Participant, Responsible Party, and their heirs and assigns, hereby agree to release and hold harmless the JLWSDP from any and all suits, actions, losses, damages, claims, and liability of any character, type or description, including any expenses of litigation,

court costs, or attorney's fees, arising out of or related in any way to the acts or omissions of physicians, dentists, or therapists, or any consequences that result from the JLWSDP's following physician, dentist, or therapist orders, so long as any such claims are not seeking redress for damages caused by the negligence of the JLWSDP.

SECTION VI
EDUCATION AND RESEARCH

The JLWSDP prides itself as a training community for medical students learning how to care for people living with dementia. Responsible Party hereby acknowledges and understands that the JLWSDP is involved in medical and nursing education, as well as research programs. Responsible Party hereby consents for Participant to be cared for by student healthcare personnel.

SECTION VII
PARTICIPANT AND RESPONSIBLE PARTY'S LIABILITY FOR DAMAGE TO JLWSDP OR PROPERTY LOCATED AT THE JLWSDP

Responsible Party hereby acknowledges and agrees that he/she will be held responsible and liable for any damage to the JLWSDP, the JLWSDP's property, or the property of other Participants of the JLWSDP, if such damage is due to behavior or actions or inactions of Participant or Responsible Party. Participant, Responsible Party, and their heirs and assigns, shall indemnify and hold the JLWSDP harmless from any and all claims, suits, and actions asserted against the JLWSDP relating to damage or injury to property or a person, including the JLWSDP, caused by Participant or Responsible Party. Responsible Party understands that the JLWSDP is liable for injuries to Participant or Participant's property only insofar as those injuries are caused by negligent or intentional wrongful acts or omissions of the JLWSDP and recoverable by law.

SECTION VIII
MISCELLANEOUS PROVISIONS

A. Governing Law and Venue:

This Agreement shall be governed and construed in accordance with the law of the State of Texas. This Agreement has been executed in and is

performable in Fort Worth, Tarrant County, Texas. The Parties agree that any dispute, controversy, or claim arising out of or relating in any way to the Agreement, including without limitation any dispute concerning the construction, validity, interpretation, enforceability, or breach of this Agreement, will be decided by a state or federal court in Tarrant County, Texas.

B. Loss of Property:

The JLWSDP shall not be liable or responsible for the loss or destruction of any personal property belonging to Participant or Responsible Party due to theft or any cause beyond the immediate control of the JLWSDP. Participant and Responsible Party shall bear responsibility over their personal property brought to JLWSDP.

C. Rules and Regulations:

Participant and Responsible Party agree to abide by all rules and regulations set in place by the JLWSDP for the operation of the JLWSDP. Participant and Responsible Party further agrees to abide by such reasonable amendments, modifications and changes to the rules and regulations of the JLWSDP as may hereafter be adopted or established by the JLWSDP.

D. Non-smoking Facility:

The JLWSDP is a non-smoking facility. Smoking is prohibited in the JLWSDP and on the JLWSDP's grounds.

E. Liability and Indemnification:

Responsible Party understands and agrees that the JLWSDP is liable for injuries only insofar as they are caused by negligent or intentional wrongful acts or omissions of the JLWSDP and recoverable by law. Participant, Responsible Party, and their heirs and assigns shall indemnify and hold the JLWSDP harmless from any and all claims, suits, and actions brought against the JLWSDP relating to damage or injury to property or a person, including the JLWSDP, caused by Participant or Responsible Party.

F. Severability:

If any provision, term, or portion of this Agreement is held invalid or unenforceable, then all other provisions and portions of the Agreement shall remain in full force and effect.

G. Entire Agreement:

This Agreement constitutes the complete agreement of the Parties, and no oral agreement to the contrary shall be binding. This Agreement supersedes all prior agreements concerning the JLWSDP. With the exception of changes to the Basic Service Fee and Supplemental Charges, this Agreement may be modified or amended only by way of a writing executed between the JLWSDP and Responsible Party (or a person succeeding Responsible Party as the duly authorized representative of Participant). This Agreement may not be assigned by Participant. The JLWSDP's rights and interests hereunder shall accrue to the JLWSDP's successors and assigns.

L. **Counterparts**:
This Agreement may be executed in counterparts, all of which executed counterparts shall together constitute a single document.

This Agreement has been executed to be effective as of the date set forth above.

________________________________ ______________________

Participant's Responsible Party Date

_________________________________ _______________________

James L. West Presbyterian Special Care Center, Date
d/b/a James L. West Senior Day Program,
a Texas nonprofit corporation

By: ____________________________

Title: ____________________________

James L. West Senior Day Program
ADDITIONAL CONDITIONS OF PARTICIPATION

1. **MEDICAL CARE**

__________ I understand that the James L. West Senior Day Program is primarily a supportive service for older adults. The Senior Day Program is not a provider of health care but does administer medication as prescribed by a participant's physician.

__________ I understand that a participant may not remain enrolled in the James L. West Senior Day Program if he/she requires more attention and assistance from a staff member than is possible with our 8:1 participant to staff ratio.

__________ I understand that the Senior Day Program assures no legal responsibility for specific treatment of health care needs, particularly those of an emergency nature. In the event of a medical emergency, the Senior Day Program will contact the responsible party to transfer or call "911" for ambulance transfer. Any advance directive paperwork will be given to the emergency responders.

__________ I further understand that the Senior Adult Day Program is not responsible for any costs incurred for emergency transportation, treatment or care resulting from accident or illness.

2. **MEDICATIONS:**

__________ To comply with Texas Health and Human Services regulations, the following requirements must be met for us to administer medications:

__________All medications must be in their original containers.

__________All prescription bottles must have the following:

- Name and address of the pharmacy;
- Participant's full name;
- Prescribing physician's name;
- Date prescription was dispensed;
- Instructions for use;
- Brand or generic name;
- Strength of drug

__________ We will not be able to give medications which are not properly labeled. It is most convenient for us to have **one week or more** supply of medicine for each participant. Most pharmacies are willing to label extra empty bottles for bringing to the day program and we will return all bottles when we need refills.
__________ Upon discharge, unused medications will be returned to the participant or his/her responsible party.

3. PROGRAM HOURS AND CLOSURES:

__________ Hours of operation are from 7:30 a.m. until 6:00 p.m. Monday-Friday.
__________ The Senior Day Program will recognize the following holidays and be closed to participants: New Year's Day; Memorial Day; Independence Day; Labor Day; Thanksgiving Day; Christmas Day.
__________ In a case of bad weather, the James L. West Senior Day Program will follow the closures of the Fort Worth ISD.

4. PARTICIPANT FEES:

__________ Hours of operation are from 7:30 a.m. until 6:00 p.m. A late fee of $5.00 for the first 15 minutes and $1 for every additional minute will be assessed for any member picked up after 6:00 p.m. Regardless of participation in tuition programs, this fee is the responsibility of the participant or responsible party.
__________ At admission, the participant and responsible party will set a schedule for which days the participant will regularly attend. This will be a “set schedule” which the participant will keep weekly and subsequently be billed for.
__________ I understand the only way to “guarantee availability” for a certain day is to have a set schedule, therefore securing a spot for the participant on those set days regardless of other reservations that may come in.
__________ Should there need to be a change in a participant’s set schedule for the next week, the participant’s responsible party will fill out a reservation form and turn into the Director of the Senior Day Program notating the change *no later than the Wednesday of the week prior to the change.*
__________ If the Director is not made aware of needed schedule changes, and the participant is a “no show” on a scheduled day, a “no show” fee of $50 will be

assessed. As a business, we staff according to the expected number of participants, and the only exception to this billing policy occur when a participant is absent due to hospitalization. The responsible party is expected to notify the program in this instance, within 24 hours of absence or expected absence.

__________ If your loved one does not have a "set schedule" then the Director of the Senior Day Program ***must receive your reservation in writing***, via either the "Reservation Form" or an email by midnight on Wednesday of the previous week. It is up to the responsible party to let the Director know when the participant is attending. The Director will advise you if a day you have chosen is "full" or if there is not a spot available. In this case, you can be put on the waiting list to be called should there be a cancellation. Should your loved one fail to attend a scheduled day, again, the $50 "no show" fee will apply, unless the participant is in the hospital.

__________ I understand that failure to comply with this payment arrangement will result in termination from the program unless other acceptable arrangements are made with the Senior Day Program Director.

__________ I understand that participant fees are subject to change upon a thirty-day notice.

__________ For participants on a tuition program, including VA benefits: the weekly schedule will still be completed. Excessive absences from the program will be cause for discharge.

5. CANCELLATION POLICY:

__________ There are no refunds for no-shows or day-of cancellations. The $50 no show fee will be charged. Any exceptions must be approved by and coordinated with the Senior Day Program Director.

6. DROP-INS:

__________ If a participant needs to add a day or "drop in" to the program, a 24-hour notice is required and will be accommodated as space permits.

7. DISCHARGE POLICY:

________I agree to accept the recommendation from the interdisciplinary team (IDT) at the Senior Day Program when another level of care for the participant is recommended. Unless a situation arises where the health and safety of the participant or other participants is at risk, I understand we will be given a 2-week notice of discharge to find the participant a new care arrangement.

____

Responsible Party Date

____

James L. West Day Program Representative Date

James L. West Senior Day Program Physician's Orders

This form must be completed by the applicant's physician prior to admission in the Senior Day Program. Completed forms can be returned via email to dayprogram@jameslwest.org or faxed to 817-877-1414.

Patient: ______________________________________Date: ____________________________

Diagnosis: ____

Known allergies: ____

Diet Order: (please check appropriate boxes below)

☐ Regular ☐ No Concentrated Sweets ☐ No Added Salt ☐ Gluten Free

☐ Mechanical Soft ☐ Chopped

Most Recent: Blood Pressure _____________ Pulse_________Weight__________

TB/Mantoux Skin Test Results: _________________ **(Required for admission)**

Date administered ________________ By whom/title____________________

Date read_______________________ By whom/title ____________________

If TB Skin test is positive:

The results of a chest x-ray ______________ Date taken__________________

I verify that to my knowledge this patient if free from communicable disease. Yes____ No____

Special instructions if patient has a communicable disease but may attend the adult day center:

____

Is the patient combative? Yes _____ No_____

Does the patient wander away from home or indicate a potential to wander? Yes____ No_____

Does the patient use mobility aids? If so, what? ____

Is the patient able to transfer independently? Yes____ No____

Limitations? ____

Is the patient incontinent? Yes_____ No_____ Bladder _____ Bowel _____

May this patient take part in range of motion activities? Yes____ No_____

Limitations? ____

I ____________________________have thoroughly examined __________________________

on_____________________ and find that he/she appropriate for the James L. West Senior Day Program.

(Print or Type)

Physician's Name ____

Address ____

____

Phone ____________________________ Fax_________________________________

____________________________________ ____________________ _______________

Physician's Signature Date NPI #

Revised 11/16/2022

James L. West Senior Day Program Physician's Orders

Patient's Name ____

Note: Please include PRN and over the counter items

Medication List

Name of Medication	Dosage	Times Given	Reason Given

Is this patient capable of self-administering medications? Yes______ No ________

Physician's permission for facility to:

Administer PRN Tylenol/Ibuprofen Yes _____ No ________
Administer PRN Tums/Mylanta Yes _____ No ________
Administer PRN Imodium Yes_____ No _______

Apply Sunscreen? Yes______ No ________
Clip/File Fingernails? Yes _____ No _________

Physician's Signature: ____

Date: ___________________________________

Revised 11/16/2022

James L. West Senior Day Program
Masking Medication Form

At times it is necessary to mask or conceal medications to get a person with dementia to take the medications. We sometimes use food item to mix with the medication.

I hereby give consent for the named Participant to have his/her medications masked at the James L. West JLWSDP in his /her best interests and safety.

______________________________	______________________
Participant's Responsible Party	Date
______________________________	______________________
James L. West Representative	Date

James L. West Senior Day Program

Authorization to Use or Disclose Health Information

I_________________________________(legal representative) authorize
___________________________________ (facility/physician) to use and/or disclose the health information of ______________________________________ (participant name/DOB) to James L. West Senior Day Program (facility/physician) for the following purpose(s):

( ) Another Facility (X) Continuing Care ( )Personal Files ( ) Insurance
( ) Legal

By checking (√) the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist, for the time period of___________________ through current:

_____ History and Physical
_____ Nurses Notes
_____ Immunization Record
_____ Social Service Notes
_____Laboratory Reports
_____Physician Orders

Other ____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do by submitting a written request to James L. West Alzheimer's Center. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: six months from date of signature.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure, and the information may not be protected by federal confidentiality rules.

_____________________________________ ______________________

Signature of Participant/Legal Representative Date

James L. West Senior Day Program Admission Application

Please complete in ink**.**

Date of Application: _______________

Applicant's Name: ____

Last *First* *Middle*

Address: ____

City: _____________________________ State: ____________ Zip: ___________

Phone: ___________________ Birthdate: _______________ Age: _____________

Gender: ________ Ethnic Origin: _____________ Primary Language: __________

Social Security # ____________________ Medicare # ______________________

Private Insurance Company and Phone: ___________________________________

Insurance Policy Number: ____

Marital Status (circle one):

Married Divorced Single Widowed Domestic Partner

Bill To: __________________________ Relationship: ________________________

Address: ____

Phone: _________________________ Email: _______________________________

Living Arrangements: Alone ______With Spouse ______ With Sibling ______

With Children ______ Other: ________________________

Emergency Contact Information

Primary Emergency Contact	**Emergency Contact #2**
Name:	Name:
Relationship:	Relationship:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:
Address:	Address:
City/Zip	City/Zip

Emergency Contact #3	**Emergency Contact #4**
Name:	Name:
Relationship:	Relationship:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email:	Email:
Address:	Address:
City/Zip	City/Zip

Note: we require information for at least 2 people who can be contacted in case of an emergency.

Primary Physician's Name: ____

Specialty: ____

Physician's Phone:____

Physician's Address: ____

When did the applicant last see the physician? ______________________________

Has the applicant been diagnosed with dementia? ___________________________

By whom? _____________________ Date of diagnosis: ______________________

Hospital Preference: ____

Other physicians seen:

1. Name, Specialty, Phone: ____
2. Name, Specialty, Phone: ____

Pharmacy: ______________________________ Phone: ______________________

Food, Drug or Environmental Allergies: _____________________________________

Immunization History:

Are you currently fully vaccinated against Covid-19? Yes_____ No_____

Have you received the booster shot? Yes_______ No _______

(If yes, please provide a copy of your Covid-19 card.)

Date of most recent flu shot: __________________Pneumonia shot: _______

Appetite: ☐ Good ☐ Fair ☐ Poor

Food likes/dislikes: ____

Preferred beverages: ____

Revised 11/16/2022

Any problems with chewing and swallowing? ______________________________
Problems with utensils? ____
Requires assistance with feeding? ____
Does the applicant use liquid nutritional supplements? _______________________

Personal Care:
Bathing and hygiene: ☐ Self ☐ Needs Assistance
☐ Resists bathing ☐ Interested in showering at the day program
Toileting:
☐ Takes self to bathroom/no accidents ☐ Occasional accidents
☐ Requires cueing and/or physical assistance ☐ Uses disposable briefs or pads

Sleeping Habits: Usual bedtime: ______________ Usual waking time: _________
Naps during the day? ___________ Length and time? ________________________

Mobility:
☐ Independent ☐ Needs Assistance ☐ Requires assistance with transfers
☐ Unsteady/Dizziness ☐ Fallen within the last 6 months: Injury? ___________
☐ Wheelchair ☐ Walker/Cane

Dentures:
☐ Full ☐ Partial ☐ Upper ☐ Lower

Eye Glasses: ___________________ Hearing Impairment? ___________________
Hearing Aid: ☐ Right ☐ Left

Has applicant been known to wander off from home or leave a secure area either at home or in a facility unattended? If so, where did applicant go and how did you prevent the situation from reoccurring? ____________________________________
____

The information I have provided in this application is current and correct to the best of my knowledge.

Signature: ____ Date: _____________
Relationship to Applicant: ____

Activity and Recreation Form

Name: ____________________________ Preferred Name: _________________________

Primary Language: ____

Other languages spoken: ____

I was born in: __________________________ I was raised in: ______________________

I consider ____________________________________ to be my home.

Veteran of the Armed Forces? Yes _____ No ______

Branch: ___________________ Rank: _________________ Years of Service: ________

Medals: ____

Religious Affiliation: ____

Applicant's trade or profession prior to retirement: __________________________

Date of last employment: ____

Family member most dependent on: ____

Relationship: ____

Activity Interests: Please check "P" if past interest, "C" for a current interest

Activity	P	C	Activity	P	C
Trips/Shopping			Volunteering/Helping others		
Games (cards, dominoes, board games, etc.)			Being outdoors		
Exercise			Social Events/Parties		
Sports			Gardening/Plants		
Reading: Books, magazines			Pets/Animals		
Arts & Crafts			Watching TV/Movies		
Music			Bible Study/Religious Services		
Cooking/Baking			Learning new things		

Hobbies and Interests: ____

____

Current or Past Church, Clubs or Memberships in Groups: ____________________
____
____

Childhood Memories: ____
____
____
____

Accomplishments: ____
____
____
____

Topics I enjoy talking about: ____
____
____

Topics that might upset me: ____
____
____

What calms me down when I get upset: ___________________________________
____

Father's Name: _______________________ My Mother's Name: ______________
Siblings: ____
Spouse: __________________________ Children: ___________________________
Other significant family members or friends: _______________________________
____
Pets: ____

Other information you should know about me:

Revised 11/16/2022

James L. West Senior Day Program

Field Trip Permission Form

_______________________________ has my permission to go on outings in and around Fort Worth with the James L. West Senior Day Program of Fort Worth as they may be scheduled.

I understand that the group will be supervised by the staff of the Senior Day Program plus any additional volunteers.

_______________________________   _____________________

Participant or Responsible Party   Date

_______________________________   _____________________

James L. West Representative   Date

James L. West Senior Day Program

Monetary or Items of Value

The JLWSDP requests that items with monetary or sentimental value not be brought into the JLWSDP. Due to the cognitive impairment of the Participants, the JLWSDP cannot be held responsible for any damage or loss to Participant items of any value. The JLWSDP will not replace lost items.

I have been informed the JLWSDP is not responsible for any valuables or money left in the care of the Participant and will not replace lost items.

Activity Funds Agreement

I, the undersigned, give permission to the administration of the JLWSDP to bill me for costs associated with activities not included in the per diem rate, not to exceed $20.00 per month.

Participants are encouraged not to bring money to the JLWSDP. $20.00 is the maximum amount that may be charged under this activity funds agreement, and these funds may not be used for physician ordered medical supplies.

__________________________________ ________________________
Participant's Responsible Party Date

__________________________________ ________________________
James L. West Representative Date

James L. West Senior Day Program

Photography Consent

I hereby give my consent for photography, filming, videotaping and/or audio recording or other means of capturing my image or voice and/or being quoted in the media or printed material (including social media websites) at James L. West Senior Day Program. Other than for the reasons listed under "Not Optional", I authorize the use or disclosure of such for the following purposes (check all that apply):

Not Optional:

1. James L. West will take a photo of each participant for Medical Reasons (identification for Medication Administration)
2. Internal Usage (Newsletters, posting within the James L. West community)

Optional:

___ Research Activities (staff or vendors) ___External Teaching

___ Marketing, Advertising and Media (Public Relations and charitable goals, JLW publications and websites, printed materials, news reporting, documentary films, commercials, television or film, social media websites, etc.)

___ I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold JLW and its personnel and affiliated programs harmless from any and all liability which may or could arise from activities authorized by this agreement.

___ This authorization expires five years after discharge date. Upon expiration of this authorization, JLW will not permit further release of any photography or information but will not be able to call back any photography or information already released.

I may request cessation of filming or recording at any time, the authorization may be rescinded, but must be completed in writing.

Additionally, I agree not to take pictures of other residents, even if they are in the background.

______________________________________ ____________________

Resident's Responsible Party Date

______________________________________ ____________________

James L. West Representative Date

Advance Directives

Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends, and health care professionals, and to avoid confusion later.

- **Directive to Physicians and Family or Surrogates Form—**This form is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury.
- **Medical Power of Attorney Form—**Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself.
- **Out-of-Hospital Do Not Resuscitate Information and Form (PDF)—** This form instructs emergency medical personnel and other healthcare professionals to forgo resuscitation attempts and to permit the patient to have a natural death with peace and dignity. This order does **NOT** affect the provision of other emergency care including comfort care.
- **Statutory Durable Power of Attorney**—This form is for designating an agent who is empowered to take certain actions regarding your property. It does not authorize anyone to make medical and other healthcare decisions for you.

Does Applicant have an Out-of-Hospital DNR? Yes _______ No ________
(If yes, please attach)
Directives for Physicians for End of Life:
Heroic Measures (aka Full Code) ___________
Allow Natural Death (aka DNR) ___________
Organ(s) Donation ____

If you do not have a DNR/Allow Natural Death or other Advanced Directive documents completed, see the Director or Nurse in the Senior Day Program and we will provide you with sample forms and can assist you in completing the documents according to your preferences.

Signature: ____________________________________ Date: ________________

Rights of the Elderly (HR 102.004)

a. An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

b. An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual:

    (1) Has the right to make the individual's own choices regarding the individual's personal affairs, care, benefits and services;

    (2) Has the right to be free from abuse, neglect, and exploitation; and

    (3) If protective measures are required, has the right to designate a guardian or representative to ensure the right to quality stewardship of the individual's affairs.

c. An elderly individual has the right to be free from physical and mental abuse, including corporal punishment or physical or chemical restraints that are administered for the purpose of discipline or convenience and not required to treat the individual's medical symptoms. A person providing services may use physical or chemical restraints only if the use is authorized in writing by a physician or the use is necessary in an emergency to protect the elderly individual or others from injury. A physician's written authorization for the use of restraints must specify the circumstances under which the restraints may be used and the duration for which the restraints may be used. Except in an emergency, restraints may only be administered by qualified medical personnel.

d. An elderly individual with an intellectual disability who has a court-appointed guardian of the person may participate in a behavior modification program involving the use of restraints or adverse stimuli only with the informed consent of the guardian.

e. An elderly individual may not be prohibited from communicating in the individual’s native language with other individuals or employees for the purpose of acquiring or providing any type of treatment, care, or services.
f. An elderly individual may complain about the individual's care or treatment. The complaint may be made anonymously or communicated by a person designated by the elderly individual. The person providing service shall promptly respond to resolve the complaint. The person providing services may not discriminate or take other punitive action against an elderly individual who makes a complaint.
g. The elderly individual is entitled to privacy while attending to personal needs and a private place for receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. An elderly person may send and receive unopened mail, and the person providing services shall ensure that the individual’s mail is sent and delivered promptly. If an elderly individual is married and the spouse is receiving similar services, the couple may share a room.
h. An elderly individual may participate in activities of social, religious, or community groups unless the participation interferes with the rights of other persons.
i. An elderly individual may manage the individual’s personal financial affairs. The elderly individual may authorize in writing another person to manage the individual’s financial affairs. The elderly individual may choose the manner of financial management, which may include management through or under a money management program, a representative payee program, a financial power of attorney, a trust, or a similar method, and the individual may choose the least restrictive of these methods. A person designated to manage an elderly individual’s financial affairs shall do so in accordance with each applicable program policy, law, or rule. On request of the elderly individual or the individual’s representative, the person designated to manage the elderly individual’s financial affairs shall make available the

related financial records and provide an accounting relating to the financial management. An elderly individual's designation of another person to manage the individual's financial affairs does not affect the individual's ability to exercise another right described by this chapter. If an elderly individual is unable to designate another person to manage the individual's financial affairs and a guardian is designated by a court, the guardian shall manage the individual's financial affairs in accordance with the Estates Code and other applicable laws.

j. An elderly individual is entitled to access to the individual's personal and clinical records. These records are confidential and may not be released without the elderly individual's consent, except the records may be released:
    (1) To another person providing services at the time the elderly individual is transferred; or
    (2) If the release is required by another law.

k. A person providing services shall fully inform an elderly individual, in language that the individual can understand, of the individual's total medical condition and shall notify the individual whenever there is a significant change in the person's medical condition.

l. An elderly individual may choose and retain a personal physician and is entitled to be fully informed in advance about treatment or care that may affect the individual's well-being.

m. An elderly individual may participate in an individual plan of care that describes the individual's medical, nursing, and psychological needs and how the needs will be met.

n. An elderly individual may refuse medical treatment after the elderly individual:
    (1) Is advised by the person providing services of the possible consequences of refusing treatment; and
    (2) Acknowledges that the individual clearly understands the consequences of refusing treatment.

o. An elderly individual may retain and use personal possessions, including clothing and furnishings, as space permits. The number of personal possessions may be limited for the health and safety of other individuals.
p. An elderly individual may refuse to perform services for the person providing services.
q. Not later than the 30th day after the date the elderly individual is admitted for service, a person providing services shall inform the individual:
    (1) Whether the individual is entitled to benefits under Medicare or Medicaid; and
    (2) Which items and services are covered by these benefits, including items or services for which the elderly individual may not be charged.
r. A person providing services may not transfer or discharge an elderly individual unless:
    (1) The transfer is for the elderly individual's welfare, and the individual's needs cannot be met by the person providing services;
    (2) The elderly individual's health is improved sufficiently so that services are no longer needed;
    (3) The elderly individual's health and safety or the health and safety of another individual would be endangered if the transfer or discharge was not made;
    (4) The person providing services ceases to operate or to participate in the program that reimburses the person providing services for the elderly individual's treatment or care; or
    (5) The elderly individual fails, after reasonable and appropriate notice, to pay for services.
s. Except in an emergency, a person providing services may not transfer or discharge an elderly individual from a residential facility until the 30th day after the date the person providing services provides written notice to the elderly individual, the individual's legal representative, or a member of the individual's family stating:

(1) That the person providing services intends to transfer or to discharge the elderly individual;
(2) The reason for the transfer or discharge listed in Subsection (r);
(3) The effective date of the transfer or discharge;
(4) If the individual is to be transferred, the location to which the individual will be transferred; and
(5) The individual's right to appeal the action and the person to whom the appeal should be directed.

t. An elderly individual may:
(1) Make a living will by executing a directive under Subchapter B, Chapter 166, Health and Safety Code;
(2) Execute a medical power of attorney under Subchapter D, Chapter 166, Health and Safety Code; or
(3) Designate a guardian in advance of need to make decisions regarding the individual's health care should the individual become incapacitated.

James L. West Senior Day Program

Items to Bring to the Day Program

Clothing:

- An extra set of clothing to be kept at the Day Program
- Any needed incontinence products

Medications:
ALL Medications need to be brought in the original containers they were dispensed from the pharmacy. The medication order from the doctor must match the way the medication is labeled on the container. Please leave all pre-set up medications at home. If you don't bring **ALL your needed medications,** you will be billed through Glenview Pharmacy for any medications we have to order for you loved one.

Items NOT ALLOWED:

- Valuables such as jewelry, heirlooms
- Knives, firearms, or any other weapon

Acknowledgment of Receipt of Information

Participant's Name: ____

I, _________________________________ the responsible party for ____ (participant) acknowledge that at the time of admission, I was given a copy of the following documents:

1. The Human Resource Code Section 102.004 on the Rights of the Elderly in Texas;
2. Advance Directives Information Sheet;
3. A copy of the Admission and Care Agreement.

____

Participant's Responsible Party Date

____

James L. West Day Program Representative Date