St. Mary's Adult Medical Day Care

24400 Mervell Dean Road, Hollywood, Maryland 20636

301-373-6515

APPLICATION FORM/ ADMISSION RECORD

CLIENT'S NAME:_____ Record #_____

Address: _____

Telephone #_____ Social Security #:_____

Date of Birth:_____ Sex: Female ☐ Male ☐ Race _____

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

Religion: _____ Past Occupation:_____

CLIENT'S CURRENT LIVING SITUATION:

☐ Alone ☐ With Spouse ☐ Other Family Member (Relationship)_____

☐ Group Home Name: _____

☐ Assisted Living Community Name: _____

☐ other (specify):_____

NAME OF PRIMARY CAREGIVER:

_____ Relationship:_____

Address: _____ Telephone #_____

Email address: _____ Alt Phone # _____

2nd contact person: _____ Relationship:_____

Address:_____ Telephone #_____

Alt Phone #_____

Next of Kin:_____ Relationship:_____

Address:_____ Telephone #_____

Case Manager: _____ Telephone #_____

Medical Assistance # (If applicable):_____

Medicare # (if applicable): _____

Primary Physician _____ Telephone:_____

Address:_____ Fax: _____

Other Medical Specialist: _____ Telephone:_____

Address: _____ Fax: _____

ADDITIONAL COMMENTS/ INFORMATION: _____

PLEASE CHECK OFF INTENDED DAYS OF ATTENDANCE:

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Starting/Admission Date: _____ Method of Pay: _____

St. Mary's Adult Medical Day Care
24400 Mervell Dean Rd., Hollywood, MD 20636
Phone: 301-373-6515 Fax: 301-373-6517
MEDICAL APPLICATION/PHYSICIAN'S ORDERS

Patient's Name: _____ D.O.B. _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ Resp. _____

Drug Allergies: _____ Food Allergies: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Chronic Illness: _____

Has patient been diagnosed with COVID19? Y N Date: _____ Was hospitalization required: Y N

Restrictive or Assistive Devices: _____

Treatments: _____

* Until further notice St. Mary's is unable to administer routine nebulizer treatments*

Number of days to attend Adult Medical Day Care _____ days per week.

Diet: All meals served by St. Mary's Adult Medical Day Care are approved by a registered dietician and suitable for persons with Diabetes, Heart Disease & Hypertension. Please choose from the following:

☐ Regular ☐ Regular, increased portions for weight gain

☐ Other: _____

Altered Texture: ____Mechanical Soft ____Puree ____Other _____

Diet Waiver for special Events? ____Yes ____No
Occasional Alcoholic Beverages? ____Yes ____No
Supervised Outings & Trips? ____Yes ____No
Able to self-medicate? ____Yes ____No

Medications:**

NAME	DOSAGE	FREQUENCY	REASON FOR MEDICATION
Tylenol 325 mg.	2 tablets	Q4 hrs. PRN	For discomfort or fever

****Must include order for Fingersticks, Insulin & Sliding Scale if necessary****

Vaccination History

FLU_____ Pneumonia_____ Shingles: _____

COVID 1st dose: _____ 2nd dose _____ Mfr._____

PATIENT NAME: _____

PPD (must have been done within the last 90 days) Date: _____ Results: _____mm
OR
CXR (taken within last year) Date: _____ Results: _____ (please provide copy)
_____ Please administer PPD at the Adult Day Center (0.1 ml Mantox Intradermally; read in 48-72 hrs)
Is the patient free from communicable disease? ____**Yes** ____**No**

Please check all that apply to the patient's mental status:
___ Confusion ___ Combative ___Withdrawn ___Poor Socialization ___Anxiety ___Wanders

Patient is oriented to: ___Person ___Place ___Time

Please list patient's sensory deficits: _____

Systems Review:

System	Normal	Abnormal	History	Present Condition
Cardiovascular				
Respiratory				
Neurological				
Endocrine				
Digestive				
Musculoskeletal				
Genitourinary				
ENT				
Other				

Frequency of Vital Signs: _____ Weekly _____ Monthly **Other:** _____

Is Patient Currently Receiving Therapy Services? ____Physical ____Psych ____OT ____Speech

Code Status: ____Full Code ____No Code Is MOLST Form Completed*? ____Yes ____ No
*VALID MOLST FORM MUST BE ATTACHED IF PATIENT IS A DNR.

Is patient able to wear a mask? If no, please list reason: _____

Please describe any other significant medical or surgical history:

Physician's Signature: _____ Date: _____

Print Physician's Name: _____

Address: _____

Phone: _____ Fax: _____

St. Mary's Adult Medical Day Care, Inc.

AUTHORIZATION TO RELEASE INFORMATION

Authorization is granted to St. Mary's Adult Medical Day Care, Inc. to release the following information:

- Demographic information to provide identification
- Financial information to establish eligibility for financial assistance
- Functional information to assist with coordination of care to:

	Department of Social Services
	Health Department
	Mental Health Clinic
	MedStar St. Mary's Hospital
	Department of Aging
	Physician
	Other:

By signing this form, you consent to our use and disclosure of protected information about treatment, payment and health care operations.

I understand that I can revoke this authorization at any time with written notification, except where disclosure has already been made based on prior consent. I am also aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

_____ _____

Print Participant Name Date of Birth

_____ _____

Signature of Participant or Responsible Party Date

_____ _____

Signature of Center Representative Date

St. Mary's Adult Medical Day Care, Inc.

PARTICIPANT FEE DETERMINATION

PARTICIPANT NAME:_____

BILLING ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

☐ I am not applying for financial assistance (Please skip to signature below. You DO NOT need to disclose financial information)

☐ I am applying for financial assistance. (Please complete information below and remit with verification documents)

NUMBER OF PERSONS IN FAMILY: (CHECK ALL THAT APPLY)
__ SELF __ SPOUSE __ DEPENDANT CHILDREN (specify number)

GROSS INCOME (Please specify if monthly or yearly)

	SELF	SPOUSE
Social Security		
SSI/Disability		
Pension/Retirement		
Annuities		
Dividends/Interest		
Other Income		
TOTAL INCOME		

TOTAL HOUSEHOLD INCOME: _____ per month _____ per year

VERIFICATION MUST BE ATTACHED (IE: SOCIAL SECURITY STATEMENT, PENSION STATEMENT OR CURRENT TAXES)

_____ _____ _____
SIGNATURE DATE

FOR OFFICE USE ONLY				
BILLING INFORMATION			START DATE: _____/_____/20____	
☐ Private	☐ OHS	☐ VA	☐ MA	☐ Other (specify)
CACFP CODE:		DAILY RATE:		
Days: ☐ M ☐ T ☐ W ☐ Th ☐ F			Transportation: Vans ☐ Client ☐	
DATE RECEIVED:		RECEIVED BY :		

St. Mary's Adult Medical Day Care, Inc.

FALLS & FIELD TRIPS RELEASE

The overall goal of St. Mary's Adult Medical Day Care is to enhance the quality of life and promote the maximum level of independence for all participants who attend.

Please read and initial:

_____ I understand that one of the Center goals is to encourage mobility for each person; therefore, there is always a potential for falls. Although the Center will do everything feasible to ensure the safety of everyone, it is not possible to provide continuous one-on-one assistance for each participant. Therefore, I clearly understand that accidental falls can occur but feel the benefits of attending outweigh the risks of falling.

_____ That included in the Center's program of scheduled activities are occasional field trips. I understand the Center will do everything feasible to ensure safety, and that an accidental fall or injury could occur but feel that the benefit of being included in a planned trip outweighs the risk of injury.

The monthly activity calendar will list the field trips offered for that month. If the participant wishes to attend a field trip that is not on their scheduled day, you must call the activity coordinator to make arrangements so that the participant can attend that day.

There are a limited number of spaces available for each trip and participants may not be able to attend every outing. Every effort will be made to ensure that all participants have an opportunity to attend at least one trip each month.

Occasionally, field trips are cancelled at the last minute due to unforeseen circumstance at the center, the host site, weather, etc.

Center staff makes every effort to insure that all trips are well planned and safe. Please recognize that an accidental fall or injury could occur while on an outing. You agree that the benefit of being included in a planned trip outweighs the risk of injury and you hold the center harmless from any and all liability unless gross negligence by the staff is proven. **By signing below, you indicate that you understand the field trip policy and the inherent risk of injury.**

Name of Participant

Signature of Family Member/ Responsible Person Date

Center Representative Date

Revised 8/2016

St. Mary's Adult Medical Day Care, Inc.

PHOTO RELEASE

St. Mary's Adult Medical Day Care requires that a photograph of each participant be taken for identification purposes. This photograph will be kept in the participant's medical record and the emergency binder.

Additionally, Center staff often takes photographs of participants during activities. These photos may be used in activities (i.e. scrap booking, framing, etc.) or hung in the center.

Photos may also be used for marketing purposes, which may include, but are not limited to use in flyers, brochures or the Center website.

Please initial as appropriate below:

_____ I understand that a photograph will be taken of me for identification purposes.

_____ I give permission _____ I DO NOT give permission
For photographs of me to be taken for use at the center.

_____ I give permission _____ I DO NOT give permission
For photographs of me to be used in marketing materials, which may include, but are not limited to flyers, brochures, and/or the website.

_____
Name of Participant

_____
Signature of Family Member/ Responsible Person Date

_____
Center Representative Date

St. Mary's Adult Medical Day Care, Inc.

MEDICATION ADMINISTRATION POLICY

St. Mary's Adult Medical Day Care, Inc. offers medication administration services to our participants who require it during the hours that they are in the center. Medications can only be administered if the conditions below are met. Medications cannot be administered outside of these established guidelines.

Medications administered by Center Health staff must be in the original container with the label indicating the following information (standard pharmacy protocol)

1. Participant's full name
2. Authorized prescriber
3. Prescription number
4. Name and dosage of the medication
5. Date of issuance
6. Expiration date
7. Refills remaining
8. Directions for use
9. Name, address and telephone number of pharmacy issuing drug.
10. Any appropriate special handling instructions regarding storage.

All medication must be administered from this bottle, not another container.

Over the counter medications must arrive in new, original, labeled bottles.

We must have a signed physician order indicating this medication has been prescribed for the participant.

PLEASE NOTE: If samples are given at the Dr. Office, label must be printed with Participant name, Medication, Dosage, directions for administering, and name of Physician.

We request that you send in enough medication to last a calendar month (based on the number of scheduled days). St. Mary's AMDC Health Staff will notify family a minimum of one week in advance when the medication(s) in the center are at a low level.

Any questions or concerns relating to the administration of medications may be addressed to the Nurse.

I have read and understand the guidelines as stated.

_____ _____

Signature of Participant or Responsible Party Date

_____ _____

Signature of Center Representative Date

St. Mary's Adult Medical Day Care, Inc.

PARTICIPANTS RIGHTS

St. Mary's Adult Medical Day Care, Inc. values and appreciates each individual enrolled in the program. Every participant is entitled to the following basic rights:

1. To be treated with consideration, respect, and full recognition of the participant's human dignity and individuality
2. To receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations
3. Privacy
4. Be free from mental, verbal, sexual, and physical abuse and neglect, involuntary seclusion, and exploitation
5. Be free from physical and chemical restraints except as permitted by state law (COMAR 10.12.04.23)
6. Confidentiality
7. Make suggestions, complaints, or present grievances on behalf of participants, or others, to the center director, government agencies, or other individuals without threat or fear of retaliation
8. Receive a prompt response, through an established complaint or grievance procedure, to any complaints, suggestions, or grievances the participant may have
9. Have access to the procedures for making complaints to the local department of social services and the office of health care quality (see reverse)
10. Participate in care planning and medical treatment
11. Refuse treatment after the possible consequences of refusing treatment is fully explained.

St. Mary's Adult Medical Day Care is also committed to ensuring that no person is excluded from participation in, or denied the benefits of its services on the basis of race, color, national origin, sex, religion, or disability as protected by Title VI of the Civil Rights Act of 1964.

If you feel that your rights have been violated in any way, please contact the Program Director immediately. If your complaint is not resolved to your satisfaction, you may file a complaint with the following agencies:

Maryland Dept. of Aging
301 West Preston St. #1007
Baltimore MD, 21201

Maryland Department of Health
Office of Health Care Quality
7120 Samuel Morse Dr., Second Floor
Columbia, MD 21046

Equal Access Compliance Unit
Office of Equal Opportunity Programs
201 West Preston St.
5th Floor
Baltimore MD, 21201

I have read, or been read, and understand my rights as a participant of St. Mary's Adult Medical Day Care. I understand the complaint procedures as outlined above.

_____ _____

Signature of Participant or Responsible Party Date

_____ _____

Signature of St. Mary's AMDC Representative Date

St. Mary's Adult Medical Day Care, Inc.

PARTICIPANT'S ADVANCE DIRECTIVES

I have received Advance Directives information, verbal or written, explaining my rights to make health care decisions, i.e. Living Will, Durable Power of Attorney for Health Care, and Maryland MOLST (Medical Orders for Life Sustaining Treatment).

The following decisions have been made about my care:

I have signed a Living Will or Advanced Directives	☐ YES ☐ NO
I have signed a Durable Health Care Power of Attorney or Assigned a HealthCare Agent	☐ YES ☐ NO
My physician has completed a MOLST Form (provide a copy)	☐ YES ☐ NO

If I have a Do Not Resuscitate (no CPR) Order, I understand it is my responsibility to obtain the documentation and bracelet from my physician. **The Center must have the proper documentation on file in order to honor your wishes.**

I understand that without the proper documentation on file at the center, the Center will call 911 and follow Center medical emergency procedures.

The Center will always try to notify the family and personal physician of any medical emergency situation as soon as possible.

I have read and understand the above information.

_____ _____

Signature of Participant or Responsible Party Date

_____ _____

Signature of Center Representative Date

HIPAA
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Complaints

If you believe that your private information has been incorrectly released without authorization, please contact the Program Director at St. Mary's Adult Medical Day Care, Inc. via phone (301-373-6515), in person or by mail: 24400 Mervell Dean Rd, Hollywood, MD 20636, or email: programdirector@stmarysamdc.com.

My signature documents that I have received a copy of this Privacy Notice and that it has been explained to me.

_____ _____

Signature or Participant or Representative Date

_____ _____

Signature or Participant or Representative Date

Meal Benefit Application for Adult Day Care Centers

July 1, 2020 – June 30, 2021

For more information, read **Instructions for Completing** or call 301-373-6515

Step 1 **List all enrolled participants (if more spaces are required for additional names, attach another sheet of paper). If a Medicaid or SSI number is provided, skip to Step 4**

First and Last Names of All ENROLLED Participants	Provide participant's Medicaid or SSI # if applicable	
	Medicaid	SSI

Step 2 **If you or your spouse or your dependent children who reside with you receive Food Supplement Program (FSP) benefits or Temporary Cash Assistance (TCA), enter one case number here.**

If you answered **NO**, complete Step 3.
If you answered **YES**, provide a case number then go to Step 4

Case Number: ☐☐☐☐☐☐☐☐☐

Step 3 **Report Income for Household Members (skip this step if you answered 'Yes' to Step 2)**

List all Household Members (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes) for each source in whole dollars only. If they do not receive income from any source, enter '0'. If you enter '0' or leave any fields blank you are certifying (promising) that there is no income to report.

How Often = Weekly, Every 2 Weeks, Monthly, Twice a Month or Yearly

First and Last Names of ALL Household Members	Earnings from Work		Child Support, Alimony, Public Assistance		Pensions, Retirement, Other Income	
	Income	How Often?	Income	How Often?	Income	How Often?

Total Household Members (Children and Adults): ☐☐

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member: ☐☐☐☐

Check if No SSN: ☐

Step 4 **Contact Information and Adult Signature**

I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that officials may verify (check) the information. I am aware that if I purposely give false information, I may be prosecuted under applicable State and Federal laws. I understand my participant's eligibility status may be shared as allowed by law.

Printed Name:		Signature:	
Street Address:			
Date:		Phone #:	

Step 5 **OPTIONAL: Participant's Racial and Ethnic Identities**

We are required to ask for information about your participant's race and ethnicity. This information is important and helps to make sure we are fully serving our community.

Ethnicity (Check One):

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (Check one or more):

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

DO NOT FILL OUT THIS SECTION. CENTER USE ONLY

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income (Children and Adults): $ _____

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

Eligibility: ☐ Free ☐ Categorically Eligible ☐ Reduced ☐ Paid

Determining Official's Signature: _____ Date: _____

Date Withdrawn: _____

St. Mary's Adult Medical Day Care, Inc.

ADMISSIONS AGREEMENT

Name: _____ Phone: _____

Address: _____ SSN: _____

_____

PURPOSE

- The purpose of St. Mary's Adult Medical Day Care is to provide a safe, structured environment and a flexible therapeutic program of services and activities, with individual plans of care, designed to permit participants to remain in their homes and communities, living as independently as possible, with dignity and a renewed sense of purpose and hope.
- St. Mary's Adult Medical Day Care provides these services to participants without regard to race, color, country of origin, religion, sex, marital status, and physical or mental handicap.

SERVICES AVAILABLE

- Services covered by the daily fee include a program of diverse educational, social and recreational experiences, assistance as needed with activities of daily living, nursing services, social services, consultation with participant's physician, nutritious meals (breakfast, lunch and a snack) and transportation to and from the center.
- A monthly activity calendar and menu are sent home via the buses each month.

GOALS

- Upon admission, the nurse, social worker, and activity director will obtain medical, social, nutritional, and recreational information from you, family members, and medical records. This information will be used to create a plan of care that will address your unique needs and goals. This care plan will be reviewed and updated periodically throughout your stay. You and/or your representative shall have access to this plan of care and be encouraged to participate in all care plan conferences. If it is determined that this program is not meeting your needs, the center staff will assist in developing a discharge plan.

DISCHARGE

- If and/or when your needs no longer require or cannot be met by St. Mary's Adult Medical Day Care, a discharge plan will be developed by the social worker, who will also assist you in obtaining the resources you need to implement the plan.

- The center may initiate discharge for the following reasons:
    - Continual disruptive behavior that cannot be changed or controlled after medical and staff interventions.
    - Participants and/or families who are unable or unwilling to cooperate with established Center policies.
    - Persons whose needs require repeated 1:1 intervention.
- Notice will be given 30 days prior to a center initiated discharge, except in the following cases:
    - The health or safety of the participant or other individuals in the center would be endangered by the continued presence of the individual
    - The participant has urgent medical needs
    - There is an emergency requiring less than 30 days notice.
- If you choose to withdraw from St. Mary's Adult Medical Day Care, we require a minimum of a two-week notice unless there are mitigating health concerns.

LEAVE OF ABSENCE

- If you are out of the center in excess of 30 days, you may be discharged. Ability to return will be determined after a re-evaluation by the center nurse and receipt of an updated medical application from your physician.

MEDICAL TREATMENT:

- Basic medical treatment is available by nursing staff at the center. In the event of a sudden illness or injury, it is understood that you give permission to be transported to St. Mary's Hospital by ambulance. Any cost incurred will be at your expense. Center staff will make every effort possible to notify your family or responsible party listed as emergency contact as well as your personal physician.

- We must have a working phone number on file to reach your emergency contacts in the event of an emergency. Failure to keep changes in phone number and address up to date may result in discharge from the program.

- The facility shall not be liable for any injuries suffered by a client while under the facility's care, except when caused by negligence of facility employees. If a client leaves or is removed from the facility for any reason, its agents and employees are released and discharged by the client from all liability for injury suffered by the client while away from the facility.

HOURS OF OPERATION

- The Center is open Monday through Friday from 7:30 am to 4:00 pm. Medical Day Care Hours are from 8:30-3:00, with extended hours from 7:30-8:30 am and 3:00-4:00 pm.

- The center is closed on New Years Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day.

CLOSING OF THE CENTER

- In the event of a delayed opening or closure due to inclement weather, Center staff will make every effort to call. You may also listen to WMDM FM 97.7, WSMD FM 98.3, or WKIK FM 102.9. The centers Facebook page will also be updated. You can like our page: https://www.facebook.com/St.MarysAMDC

- In the event of early closing due to inclement weather, we will contact the name provided as the emergency contact. A responsible party must be available in the event of the center closing early.

ATTENDANCE

- You may attend a minimum of two (2) days or up to a maximum of five (5) days per week.

- The days that you plan to attend the Center are:

  ____Monday ____Tuesday ____Wednesday ____Thursday ____Friday

- You are expected to attend the center based on the schedule that you have agreed to.

- For same day absences, please contact the center as soon as you are aware that you will be absent. The center has a 24-hour voicemail service. The center opens at 7:30 am each day if you prefer to speak with someone.

- Please communicate all information regarding absences with the Director.

ADDITIONAL DAYS:

- If you wish to add a day to your schedule, please contact the Director. We will do our best to accommodate your request, however we cannot guarantee a space will be available. The following month's bill will reflect the added day.

TRANSPORTATION ARRANGEMENTS:

_____ I choose to use the Center transportation. ___am ___pm ___both

_____ I will provide my own transportation. (see hours of operation)

If choosing to use Center transportation, refer to Transportation agreement for an explanation of our transportation services and policies.

BILLING

Self-Pay

- Client and/or Representative agree to pay the Facility the sum of $_____ (dollars) per day of services, for an agreed number of days per month, which is payable monthly. The Facility may change the daily rate only upon thirty (30) days advance written notice to the Client and/or Representative.

- After the first month, bills for days attended will be sent on the first day of each month and are ***payable upon receipt***, no later than the 10th of the month. If unable to keep this commitment due to unusual circumstances, please call to arrange a meeting with the Director.

- All bills not paid by the 10th of the month will incur a 1% late charge, UNLESS arrangements have been made with the Business Office.

- Payment can be made by check or money order made payable to St. Mary's Adult Medical Day Care, Inc. We do not accept credit card payments at this time. Payments should be mailed to our Business Office at 6401 Dogwood Road, Ste. 108, Baltimore, MD 21207.

- In the event of failure or refusal to pay any amounts charged under the terms of this agreement, client and /or representative agree to pay attorney's fees in the amount of (25%) of the outstanding balance due or $250, whichever is greater, in addition to all charges, expenses, and court costs attributable to collection and/or litigation including but not limited to filing fees, private process fees and related costs.

Third Party Payment

- Community Type Medical Assistance is accepted for Day Care Services if the participant meets both the financial and medical requirements. All basic services and some optional services are included in the per diem.

- Client and/or representative accept full financial responsibility for and agree to pay the full amount charged by the facility in the event that any third party payer shall deny coverage of or responsibility for client's claim or any party payer shall deny coverage of or responsibility for client's claim or any part thereof. For the purposes of this paragraph, the phrase "third party" shall include the US Department of Health and Human Services, Social Security Administration, State Welfare Agencies, Insurance Companies, and any authorized official or unofficial payer. With respect to Medicaid, denial of coverage shall mean the disqualification of the client as beneficiary under the program. Client and or representative agree to observe, submit to, and obey all current and future rules and regulations established in connection with the operation and maintenance of the facility.

- Client and/or representative hereby certify that the information given to them to enable the facility to apply for payment under Title XVII and XIX of the Social Security Act is correct; further

that the facility is hereby authorized and directed to release information concerning Client to other medical facilities, insurance companies, Federal and State Agencies, and regulatory bodies, in connection with any illness or treatment to be rendered, to the extent necessary to obtain payment and otherwise comply with applicable laws and regulations

FINANCIAL AGREEMENT

- Client and or representative agree to reimburse the facility for loss or damage suffered by the facility as a result of negligence on the part of the client. Client and/or Representative agree to indemnify and hold harmless Facility for any injury to the person or property of others resulting from the negligence of the client.

- This confession of judgment clause is included in this financial agreement and is executed on this date herewith. If payment of any amount due under this agreement, or any part thereof, shall not be made when due, the undersigned hereby authorize and empower any attorney of any Court of Record within the United States to appear for the undersigned, either jointly or severally, in favor of the Facility for the amount due hereunder with interest and cost of sit and attorney fees of twenty five percent (25%) of the amount due or $250, whichever is greater.

- If this agreement is referred to any attorney for collection and payment is obtained without entry of judgment, then the undersigned shall pay the Facility's attorney fees in the amount foresaid. If there are more than one undersigned, their liability shall be joint and several, and any use of the singular therein may also refer to the plural and vice versa and the use of any gender shall be applicable to all genders.

I or we have read, or been read, and fully understand the Admissions Criteria and agree to the conditions set forth therein.

I or we hereby agree to be jointly and severally liable for compliance with all terms and conditions of the Admission Agreement.

I, or we, agree to be responsible and to pay for, when due, all sums due and owing, to St. Mary's Adult Medical Day Care, Inc. for the above named client in accordance with all terms and conditions which I or we agree to abide by.

_____ _____

Signature of Participant or Representative Date

_____ _____

Signature of Center Representative Date

St. Mary's Adult Medical Day Care, Inc.
24400 Mervell Dean Road, Hollywood, Maryland 20636
301-373-6515

TRANSPORTATION INFORMATION

Participant's Name: _____ Date: _____ Race: _____

Mailing Address: _____

Street Address: _____

Phone Number: _____

Caregiver's Name: _____ Relationship: _____

Address: _____

Phone: _____

Directions to Home: _____

_____

_____

Check all that apply:

____ Ambulatory ____ Use wheelchair for transport ____ Assistance Required

____ Cane ____ Walker ____ Confused Sometimes

____ Wheelchair Ramp ____ Visually Impaired ____ Dementia/Alzheimer's

____ Hearing Impaired

Medical Condition Comments: _____

_____

Is there anyone home when the participant arrives home: _____ Yes _____No

Can the participant remain home alone/unattended? _____Yes _____ No

I do/ do not give permission for:_____ to remain home alone.

Signature of Participant/Caregiver: _____

Date: _____

Internal Use Only

Scheduled attendance days_____Wheelchair transport?_____

Driver Assigned _____ Date Assigned_____

Date Completed_____

Pickup time _____

Drop off time_____

St. Mary's Adult Medical Day Care, Inc is committed to ensuring that no person is excluded from participation in, or denied the benefits of its transportation services on the basis of race, color or national origin, as protected by Title VI in the Federal Transit Administration (FTA) Circular 4702.1B. For additional information on St. Mary's Adult Medical Day Care, Inc's nondiscrimination policies and procedures, or to file a complaint, please contact the Program Director, St. Mary's Adult Medical Day Care, Inc, 24400 Mervell Dean Road, Hollywood, Maryland 20636.

St. Mary's Adult Medical Day Care Center, Inc.

Participant Information

Name: _____

Date: _____

General History

Birthplace: _____

Where was participant born and raised: _____

Where did participant live most of adult life: _____

Highest education completed: _____

Occupation: _____

Religious affiliation: _____

Veteran: Yes/No What branch of service and years served? _____

Family information

Marital status: Married/Widowed/Divorced/Single _____

Children/Grandchildren/Great Grandchildren:

_____

Significant supportive family members in participant's life:

_____

Current Status

Living arrangements (where does participant live and with whom):

_____

Who are participants support systems? (Family, neighbors, church members, hired caregivers, etc.)

_____

_____

Is participant involved with any other community agencies? (Department of Social Services, Office on Aging, Health Department, Senior Centers, clubs, church, VA)

_____

_____

If participant is involved with other community agencies, please provide names and numbers for community support workers:

_____

_____

Does participant need more assistance with caregiving/equipment/finances/etc? Please be specific:

_____

_____

History of depression/anxiety or other mental health diagnoses?:

_____

Mental health treatment (past or present): Yes/No Reason: _____

Are there any behavioral problems we can expect? Suggestions for handling?

_____

_____

Participant Interests

Reading Puzzles Painting Drawing Bowling History Cooking
Singing Church Services Games Arts/Crafts Gardening Cards
Manicures Bingo Field Trips Shopping Out to lunch Music

Other interests: _____

Favorite Foods: _____

Food Dislikes: _____

Food Allergies: _____

What other information would be helpful to know to help participant adjust to Adult Medical Day Care?

_____

_____

_____

_____