The Respite Center
Criteria for Admission

Admission to the Alzheimer’s Services Respite Center is determined after completion of the following:

- **Written confirmation by a physician** of a diagnosis of early to moderate stage Alzheimer’s or related memory impairment disorder, including statement from physician of diet (i.e. regular, diabetic, etc.)
- Admissions Paperwork including:
  - Criteria for Admission
  - Admissions Application
  - Financial Responsibility Form
  - IRB Form
  - Emergency Contact Information
  - Physician Statement
  - Medication Profile
  - Emergency Medical Care
  - Confidentiality Statement
  - Participation Consent & Waiver
  - Grievance/Complaint Procedure
  - Photography/Video Release
  - Client Profile – “My Story”
  - 2017 Respite Care Services Funding Guidelines
  - Safe Return Application
  - GOEA/LA Independent Living Assessment Form (EBRCOA CONGREGATE MEALS)
  - Mini Mental Status Exam administered by Alzheimer’s Services
  - Care Plan form completed by Alzheimer’s Services

Additional Criteria:

- Client **must not** have a pre-existing medical condition that renders it impossible for him/her to participate in the activities of the program.
- **Medical care is not administered by Respite Center staff, therefore,** the Client **must not** require medical treatment such as injections, dressing change, or oral medication administration during the time she/he is at the program.
- Client **must be able to toilet and feed him/herself**
- Client **must be ambulatory.** Assistive devices such as walkers and/or canes are allowed. No wheelchairs are allowed
Part I: Information about the Caregiver

Caregiver’s Name ____________________________________________________________

Address ____________________________________________________________________

City __________________________ State ______ Zip __________ Phone __________

Parish: _______________ Gender: ☐ Male ☐ Female

Caregiver EMAIL: ____________________________________________________________

Caregiver’s Marital Status: ☐ Single ☐ Married/Domestic Partner ☐ Widowed ☐ Other _____________

Caregiver’s Date of Birth: ________________

Caregiver’s Race:
☐ White ☐ Asian (race: ____________________)
☐ African-American ☐ Pacific Islander (race: ________________)
☐ American Indian or Alaska Native (principal tribe ________________)

Caregiver’s Fluent languages:
☐ English ☐ Spanish ☐ French ☐ Other: __________________________

Caregiver’s Employment status:
☐ Works full-time ☐ Homemaker
☐ Works part-time ☐ Unemployed
☐ Retired; works part-time ☐ Other ______________________________
☐ Retired

What is the highest grade in school that the caregiver completed?
☐ 8th grade or less ☐ Associate Degree
☐ Attended high school ☐ Bachelor’s Degree
☐ High school graduate (diploma or GED) ☐ Graduate degree or higher
☐ Some college or post high school training

Caregiver’s relationship to client/elder:
☐ no caregiver identified ☐ spouse/domestic partner ☐ child/child-in-law ☐ sibling
☐ other relative ☐ friend/neighbor ☐ professional care manager ☐ other: __________________________

Today’s Date: __________________________

Alzheimer’s Services Respite Center
Program/Respite Center/Admissions/Forms/Admissions Application
Rev. March 2011
Page 1
Part II. Information about Client/Care Receiver

Client Name ___________________________ Social Security No. ___________________________

Address __________________________________________________________________________

City ___________________________ State ______ Zip ___________ Phone ________________

Parish: ___________________________ Gender: ☐ Male ☐ Female

Client Marital Status: ☐ Single ☐ Married/Domestic Partner ☐ Widowed ☐ Other __________________

Date of Marriage: ______________________ Client/Elder’s Date of Birth: ______________________

Client Height ________ Client Weight _______________ Color of Eyes __________ Color of Hair __________

Client is ☐ Right-Handed ☐ Left-Handed Is Client a Veteran/Spouse of Veteran ☐ Y ☐ N

Physician Name: ___________________________ Physician Phone: ___________________________

Client’s Race:
☐ White ☐ Asian (race: __________________________)
☐ Black, African-American or Negro ☐ Pacific Islander (race: __________________________)
☐ American Indian or Alaska Native (principal tribe __________________________)

Client’s Fluent languages:
☐ English ☐ French
☐ Spanish ☐ Other, list: __________________________

Physician’s diagnosis (select one)
☐ Dementia ☐ Vascular
☐ Alzheimer Disease ☐ Frontal Temporal Lobe Dementia
☐ Pick’s Disease ☐ Parkinson’s
☐ Mild Cognitive Impairment ☐ Other related disorder, explain __________________________
☐ Lewy Body Dementia ☐ Has not been diagnosed; Alzheimer’s or other dementia is suspected

Approximate year of diagnosis: ___________________________

Approximate date caregiver first noticed client/elder having memory problems: ___________________________
Which stage did the physician say the client is in or do you think he/she is in:

- **Stage I: Mild**
  - Repeating themselves
  - Getting lost in familiar places
  - Losing interest in hobbies
  - Forgetting common items
  - Losing things more often
  - Personality change

- **Stage II: Moderate**
  - Confused about recent events
  - Not recognizing self in mirror
  - Not recognizing family
  - Unable to care for self
  - Anxiety and/or depression

- **Stage III: Severe**
  - Inability to understand words
  - Difficulty with simple tasks
  - Arguing frequently
  - Believing things are real that are not
  - Repetitive actions or speech

Where does the client reside?

- Lives alone in house or an apartment.
  - How many people including client/elder live in house/apartment? _____

- Lives in house or apartment with others.
  - How many people including client/elder live in house/apartment? _____

- Lives in a group environment with assistance (not a nursing home)
- Lives in nursing home
- Other ________________________________________________________________________

Does the client live with the primary caregiver?  ☐ Yes  ☐ No

Geographic location of client’s residence:

- rural or farm community (fewer than 2,500)
- small city or town that is not suburb of a larger city (2,500 – 50,000)
- medium city or suburb of a medium city (50,000 – 100,000)
- large city or suburb of a large city (100,000 plus)
- Indian reservation
- Other: ________________________________________________________________________

**PART III. Respite Center Enrollment.**

Who referred you to the Alzheimer’s Services Respite Center? ____________________________________________

How much help, if any, does the client need with each of these activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Needs no help/supervision</th>
<th>Needs some help/occasional supervision</th>
<th>Needs a lot of help/constant supervision</th>
<th>Can’t do it at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Getting in and out of bed</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Getting around inside</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dressing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Bathing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Using the toilet</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Doing heavy housework</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Doing light housework</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Doing laundry</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Cooking/preparing meals □ □ □ □ □
Buying/getting food/clothes □ □ □ □ □
Getting around outside □ □ □ □ □
Going places outside of walking distance □ □ □ □ □
Managing money □ □ □ □ □
Taking medicine □ □ □ □ □
Using telephone □ □ □ □ □

In a typical week, how many hours total did the caregiver help client with:

Eating, bathing, dressing or helping with toilet functions
Meal preparation, laundry or light housework
Providing transportation to appointments and/or shopping
Legal matters, banking or money matters

Which of the following services are the client and/or family currently using? (Check ALL services that are used by either the client/elder OR the caregiver)

- Companion or friendly visitor □
- Supervision □
- Homemaker services □
- Chore services □
- Personal care services □
- Home health services □
- Adult daycare center/adult day health □
- Respite in a nursing home, adult foster home, or someone else’s home □
- Transportation services □
- Case management □
- Support groups □
- Caregiver training program □
- Psychological counseling □
- Group meals/home delivered meals □
- Other service: _____________________________

CONTINUE TO NEXT PAGE
**Client Behavioral Information**

For the following questions, check yes or no. Briefly explain or expand upon answers, as needed, in the space provided.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the client manageable for you at home at this time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home, does the client/elder have problems with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. sleep patterns:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. eating habits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. mobility:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. wandering:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. incontinence:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. level of anxiety:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. level of cooperation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. level of contentment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. expressions of happiness:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. other (e.g., change in medication):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Using the following scale, please rate the client’s present day level of loneliness, helplessness, and boredom by circling the number of the best description for each.

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>Some of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Helplessness</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Boredom</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Client Health and Demographic Information**

Number and type of chronic diseases or physical impairments he/she has (check all that apply):

- None
- diabetes
- heart disease
- arthritis
- hypertension
- other

Number of visits by the doctor he/she has had in the past 12 months:

- none
- 1 to 3
- 4 to 6
- over 6

Number of hospital stays he/she has had in the past 12 months:

- none
- 1 to 3
- 4 to 6
- over 6

Number of physician prescribed medications he/she is currently taking:

- 1 to 4
- 5 to 8
- over 9

Does the client use any of the following appliances or aids? (check all that apply)

- Wheelchair
- Cane
- Walker
- Hearing Aid (right left)
- Eyeglasses
- Dentures (upper lower)

Does the client have difficulty with food, eating or swallowing?

- No
- Yes Please describe: ____________________________

Does the client follow a special diet?

- No
- Yes Please describe: ____________________________

Does the client have any allergies? (Includes food, drugs and environment)

- Drugs:
- Pollen
- Eggs
- Sulfac
- Dairy Products
- Insect Bites
- Other: ____________________________
**Future Directions**
What other information would be helpful to you?

Please rate your interest in attending an educational workshop on each the following topics:

<table>
<thead>
<tr>
<th>Topic</th>
<th>No Interest</th>
<th>A little</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence care</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Adaptive equipment (clothing, special utensils, etc)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Nutrition and dietary concerns</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Managing problem behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other ____________________________</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
My name is _________________________ and I like to be called ____________.

I was born on _________________________ in _________________________.

_________________________ is the name of my partner in life, but I like to call him/her ____________. I want you to know that my partner in life is _______________ 

Full Name

Nickname

Describe

We have ____________ children. Our children are __________________.

Number

Describe

Their names are ___________________________________. Our grandchildren include

First Names

We even have great grandchildren! Their names are ___________________________________.

First Names

I have to tell you that my religious preference is _________________________.

Religion

I grew up in the _________________________ faith.

Religion

Growing up I attended _________________________ in _________________________

Name of School

City, State

___________. I continued my education at _________________________ where I

Name of School

obtained my _________________________

Degree/Professional Certification

To relax I always turn to _________________________; especially when something really bothers me like _________________________. Music also helps to

Activity

Pet Peeve

sooth me at times. The best music for me to listen to is ___________________.

Type of Music
# Let Me Tell You About My Day

Each day my morning begins at ____________ with the same routine; first, I ________ and then I __________. For breakfast, my favorite food is __________. My afternoon routine includes many things but one thing I do not skip is __________. I like to keep my nighttime routine as well, which includes __________. I like to be in bed by __________. Like everyone, I enjoy naps, usually at __________.

I never leave home without my __________. __________ is my favorite outfit.

I do need some assistance but only when I ask. Assisting me usually involves ________ due to my vision. Due to my hearing, assistance usually means ________. My memory is ________ so assistance usually involves ________. In restrooms, I need help ________. I like to be independent as much as possible, especially ________.

To cook for me you need to know that my favorite food is __________ but I cannot tolerate ________. My allergies include __________.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Time and Location</th>
</tr>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Activity</th>
<th>Activity</th>
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<table>
<thead>
<tr>
<th>Breakfast Food Item</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Security Item</th>
<th>Item of Clothing</th>
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<tbody>
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<table>
<thead>
<tr>
<th>What helps?</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>What helps?</th>
<th>Independent Activity</th>
</tr>
</thead>
<tbody>
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<td></td>
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<table>
<thead>
<tr>
<th>Favorite Food</th>
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<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Disliked Food</th>
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<td></td>
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<table>
<thead>
<tr>
<th>Allergies</th>
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</table>
I grew up in the _______________________. My parents’ names were
_________________________ and ___________________________ but I call them
Father
_________________________ and ___________________________. I have ________ siblings, their
Mother
names are ______________________________. My parents made a living by
Nickname
_________________________.
Nickname
First Names
Number
Parents’ Occupation

The love story between my partner and me began when we met _______________
Tell the Story
____________________________________________________________. We have been
together ____________________. My favorite memory of us is ________________
Years
Tell the Story
______________________________________________________________.

During my lifetime I have lived in ____________________________ and worked
Cite, State
as a _______________________. My occupation was _________________________.
Occupation
Describe
My military service includes _________________________ at ____________________.
Branch
Location

During my life I traveled to __________________________ but my favorite place
Places Visited
of all to visit is _______________________. One of my favorite memories is when
Favorite Location
____________________________________________________________.

Describe a Favorite Memory of Traveling
____________________________________________________________.
As I grew up, my favorite thing to do was ____________________. Now, my favorite television show to watch is ____________________ and my favorite movie is ________________.

I grew up playing games with _________________________ and we loved to play __________________________. But those were just for fun, it got serious in school when I played _________________________. My favorite activity to do inside, maybe on a rainy day is to _________________________. But if the weather is pretty I like to go outside to _________________________.

I am skilled at _______________________ but I am talented at ______________________. When it comes to making my own music, I play ___________________________. Because of my interests and my skills, my hobbies include ____________________________________.

Animals to me are _________________________. My favorite animals are _____ _______________________. Pets I have owned include _________________________.

My favorite pet I ever had was named ________________________ this one was my favorite because __________________________________________________________.
Let Me Tell You About My Values

Having a purpose in my life is important. Daily, I enjoy relaxing by ___________ Activity because it brings purpose to my life. Other things that bring meaning and purpose to my life include _____________________________. Meaningful Activities

I have done good things in my life but I believe I am most proud of ___________ Achievement. ___________ is my most prized possession Important Item because _______________. To me, my education means ______________. Describe the Item’s Importance

My ethnicity is a ___________ part of who I am. I identify as ___________. How Important? Ethnicity

One thing I would like you to know about my culture is ___________. I am fluent in ______________. Language(s)

My spirituality is a ___________ part of who I am. I express my spirituality daily How Important? Activity by _______________ and less often, yet still important to me, I always participate in ___________________________. Spiritual/Religious Tradition

You need to know that my values include ___________________________. Describe Personal Value System

______________________________.
Alzheimer’s Services is pleased to be able to supplement Respite Care Services with grant funding. Please choose one of the programs listed to receive Respite Care Services Funding:

☐ Charlie’s Place Respite Center
   *The Charlie’s Place fee is $65/day. In order to serve more caregivers who may need this financial assistance, please consider your need before enrolling in this program.*

☐ Caregiver Respite Reimbursement Program

The following guidelines apply:

- The grant benefit will be a maximum gift of $600 in a 12 month period.
- If you choose the Charlie’s Place option, the supplement will be automatically deducted on the Charlie’s Place invoice according to days attended (benefit is $15 per day; you are responsible for the balance of the fee) Maximum $600 total benefit.
- If you choose the Caregiver Respite Reimbursement Program option, the benefit is $100 per month (maximum $600 total benefit)
- Recipients have 12 months to use the $600 gift
- Recipients must have a physician’s diagnosis of dementia to participate
- The recipient must reside within our 10 parish service area
- Re-enrollment is based on a waiting list; those who have never participated in the program have priority on the list.
- If recipient receives long term care benefits, he/she is ineligible for the respite reimbursement program.
- This program is based on funding availability, no amount of funding is guaranteed.
- This form must be signed and filed with Alzheimer’s Services before any Respite Care Services funding can begin.

I understand and agree with the guidelines of the Alzheimer’s Services Respite Care Services Funding Program.

_________________________                  ________________________
Signature of Caregiver to receive reimbursement     Date

_________________________
Name of Memory Impaired Individual

Reviewed by: _______________________
Date: _______________________

Respitecenter/billing/respitecareservicesfundingguidelines/June, 2015
Information contained in the files/records of the Alzheimer’s Services Respite Center is confidential. All employees are required to sign a confidentiality agreement.

How we may use & disclose information about Respite Center clients:
In some circumstances we may use or disclose information about a client’s participation in the Respite Service program. These circumstances include:

1. **To obtain emergency medical treatment**
2. **Fundraising Activities.** We may contact you as part of our effort to raise funds for Alzheimer’s Services of the Capital Area. We will only use your photo or information with your written permission.
3. **Research.** All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with the clients’ need for privacy. We will seek your permission to include your loved one in any research projects.
4. **As Required by Law.** We will disclose information about clients when required to do so by federal, state or local law.
5. **To Avert a Serious Threat to Health or Safety.** We may use and disclose information about clients when necessary to prevent a serious threat to his/her health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
6. **Workers’ Compensation.** We may release information about clients for workers’ compensation or similar programs. These programs provide for work-related injuries or illnesses.
7. **Public Health Risks.** We may disclose information about clients for public health activities. These activities generally include the following:
   a. to prevent or control disease, injury or disability
   b. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
   c. to notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence.
8. **Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
9. **Law Enforcement.** We may release client information if asked to do so by a law enforcement official:
   a. In response to a court order, subpoena, warrant, summons or similar process
   b. To identify or locate a suspect, fugitive, material witness, or missing person
   c. About the victim of a crime, if, under certain limited circumstances, we are unable to obtain the person’s agreement
   d. About criminal conduct at the organization
   e. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

**Your Rights**
You have the right to:

1. **Request Confidential Communications.** For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make you request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.
2. **A Paper Copy of this Notice.** You will be given a copy of this notice upon acceptance into the Alzheimer’s Services Respite Center program.

Additionally, the Alzheimer’s Services Respite Center maintains a **Client Bill of Rights** which is included in the Family handbook.

I agree to abide by the policies for Confidentiality Statement.

NAME __________________________ DATE __________________________
Respite Care Reimbursement Services Funding Guidelines

Alzheimer’s Services is pleased to be able to supplement Respite Care Services with grant funding. Please choose one of the programs listed to receive Respite Care Services Funding:

☐ Charlie’s Place Respite Center Reimbursement Program
   
   The Charlie’s Place fee is $65/day. In order to serve more caregivers who may need this financial assistance, please consider your need before enrolling in this program.

   You are ineligible if you are receiving benefits from a Long Term Care Service Provider.

☐ Caregiver Respite Reimbursement Program (at home care)

The following guidelines apply:

- If you choose the Charlie’s Place option, the supplement will be automatically deducted on the Charlie’s Place invoice according to days attended (benefit is $15 per day; you are responsible for the balance of the fee)
- If you choose the Caregiver Respite Reimbursement Program option, the benefit is $100 per month (maximum $600 total benefit)
- Recipients must have a physicians diagnosis of dementia to participate
- The recipient must reside within our 10 parish service area
- Re-enrollment is based on a waiting list; those who have never participated in the program have priority on the list
- This program is based on funding availability, no amount of funding is guaranteed
- This form must be signed and filed with Alzheimer’s Services before any Respite Care Services funding can begin

I understand and agree with the guidelines of the Alzheimer’s Services Respite Care Services Funding Program.

___________________________________
Signature of Caregiver to receive reimbursement
______________________________
Date

___________________________________
Name of Memory Impaired Individual

Reviewed by: _________________________
Date: ____________________________

Respitecenter/billing/respitecare/servicesfundingguidelines/06/03/15
Client’s Name: ______________________ Date: __________________

Please list at least two people we can contact in case of emergency.

**Emergency Contact #1**

Name: ______________________________ Relationship: __________

Address: ______________________________________________________

City: ___________________________ State: __________ Zip: __________

Daytime Phone: _______________ Cell Phone: _______________

**Emergency Contact #2**

Name: ______________________________ Relationship: __________

Address: ______________________________________________________

City: ___________________________ State: __________ Zip: __________

Daytime Phone: _______________ Cell Phone: _______________

**Optional Emergency Contact**

Name: ______________________________ Relationship: __________

Address: ______________________________________________________

City: ___________________________ State: __________ Zip: __________

Daytime Phone: _______________ Cell Phone: _______________
**GOVERNOR'S OFFICE OF ELDERLY AFFAIRS**
*Louisiana Independent Living Assessment (LILA)*
*Statewide Comprehensive Needs Assessment Form*

<table>
<thead>
<tr>
<th>COVER SHEET</th>
<th>Re-Assessment</th>
<th>Client’s Initials</th>
<th>Client a Veteran? Y N</th>
<th>Nutrition Score</th>
<th>ADL IADLs</th>
<th>Client a Veteran dependent? Y N</th>
</tr>
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<tbody>
<tr>
<td>Assessment Date:</td>
<td>Re-Assessment Date:</td>
<td>Client’s Initials:</td>
<td>Client a Veteran? Y N</td>
<td>Nutrition Score:</td>
<td>ADL IADLs:</td>
<td>Client a Veteran dependent? Y N:</td>
</tr>
</tbody>
</table>

- **First Name:**
- **Middle Name:**
- **Last Name:**
- **Client’s Suffix:**
- **Client’s Maiden Name:**
- **Client’s AKA Name:**

- **Marital Status:**
  - D=Divorced
  - L=Legally Separated
  - M=Married
  - S=Single
  - W=Widowed
- **Client’s SS # Last 4 only:**
- **Client’s ID #:**

- **Client’s Residence Address:**
  - Street/P.O. Box:
  - Town:
  - State: Zip Code:

- **Client’s Mailing Address:**
  - Street Address:
  - Town:
  - State: Zip Code:

- **Information Release Authorization:**
  - Y=Yes
  - N=No

- **Client’s Age in Years:**
- **Client’s Date of Birth:** __/__/____
- **Client’s Home Phone:** (____)______
- **COA MEMBERSHIP ACCEPTED:**
- **COA MEMBERSHIP DECLINED:**

- **Ethnicity**
  - H=Hispanic or L=Latino
  - N=Not Hispanic or Latino
  - U=Unknown
  - Lives Alone? Y N
  - In Poverty? Y N
  - High Nutritional Risk? Y N
  - Is Client Rural? D D

- **Number of ADL’s:**
- **Number of IADL’s:**

- **Insurance**
  - Medicaid #
  - Medicaid Policy #
  - Medicare #
  - Medical Assistance ID

---

*Please Complete Only the Items Noted With An Asterisk*
<table>
<thead>
<tr>
<th><strong>Do you have prescription drug insurance?</strong></th>
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<tbody>
<tr>
<td>o-Y=Yes  o-N=No  o-D=Don't know</td>
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<tr>
<th><strong>Donations the client has been advised that he/she has an opportunity to make voluntary and anonymous donations for any service they may receive.</strong></th>
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<tbody>
<tr>
<td>o-Y=Yes  o-N=No  o-D=Don't know</td>
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<tr>
<th><strong>The client formally authorized release of information. Attached copy of signed and dated authorization to this assessment.</strong></th>
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<tbody>
<tr>
<td>o-Y=Yes  o-N=No  o-D=Don't know</td>
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<th><strong>Clients Signature:</strong>  <strong>Date:</strong></th>
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<tr>
<th><strong>Assessor's Signature:</strong>  <strong>Date:</strong></th>
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</table>

List all services the client will receive in the bottom of this form.
MEDICATION REVIEW (Addendum to PAF4019)

A. MEDICATION USE: (Ask the client if you can see the medications so that you can verify frequency, dosage, etc. Include over the counter drugs like aspirin, laxatives, and vitamins. Some medicines may be refrigerated.)

1. Are you taking any medicines? If so, could you show them to me so we can list their names and dosage?

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>PRIMARY DIAGNOSIS</th>
<th>DIRECTIONS/STRENGTH/DOSAGE</th>
<th>PRESCRIBING DOCTOR AND PHONE</th>
<th>MANUFACTURER AND COST</th>
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2. Do you have problems or difficulty remembering to take your medications? a. □ Yes b. □ No
(If necessary, prompt the client by asking if s/he is concerned about forgetting. What steps does s/he take to remember?)

3. Please list your drug allergies: ________________________

4. Referral made: ________
Waiver of Confidentiality

Name: ______________________ Address: ______________________

Social Security #: ______________________

I, ______________________, understand that the information contained in my Records are confidential. However, I give my consent for ______________________

To release to and/or from the East Baton Rouge Council on the Aging a copy of any information, which might be pertinent for case evaluation.

I also give permission for the East Baton Rouge Council on the Aging to give information to doctors and/or professionals involved in my case management when, in the discretion of the Council on Aging's administrative staff, it would be beneficial for my case.

This consent is subject to written revocation at any time except to the extent that action has already been taken.

I further agree that this authorization shall be valid and effective unless and until it is revoked by me in writing and that a photocopy of this authorization may serve as the original.

Client ______________________ Date ______________________

Witness/EBR COA Representative ______________________ Date ______________________

An Equal Opportunity Employer
Charlie’s Place Admission Application – Responsible Party Form

Responsible Party: If Other than Client, please complete

Name __________________________________________________________

Relationship to Client ____________________________________________

Address, if other than same _______________________________________

_______________________________________________________________

Home Phone (___) ________________________ Work Phone ( ___) ________________________

Cell/Mobile Number: (____) ________________________ Social Security # __________________

Responsible Party’s Birthdate ________________________________

Employer Name & Address _________________________________________

Financial Responsibility Statement

I acknowledge responsibility for payment of all Charlie’s Place fees. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees.

x ___________________________________________ Date __________________________
Signature of Responsible Party

x ____________________________________________
Printed Name of Responsible Party
The Respite Center
Grievance/Complaint Procedure

The following procedure should be followed in case of a grievance or complaint.

**Grievance Policy for Program Participant**

Alzheimer’s Services is committed to addressing problems when they occur. If the staff is unable to satisfactorily resolve a program participant complaint, staff members are expected to bring the issue to the attention of their immediate supervisor or the Executive Director. Program participants are encouraged to bring any unresolved problems or concerns to the attention of the Executive Director or the Board Chair at the earliest possible time.

Grievance/Complaint Procedure for Program Participants

The following procedure should be followed in case of a grievance or complaint.

1. Contact the appropriate Alzheimer’s Services of the Capital Area employee: Executive Director, Director of Services & Operations, Fund Development, Program Director, Respite Center Coordinator, or Development Director.

2. Appropriate action will be taken and may include:
   a. Review and investigation of the grievance/complaint by the Executive Director and other staff and/or members of the board of directors
   b. A conference including all parties involved if warranted
   c. Report of the outcome of the grievance/complaint to the reporting party

3. If the party is not satisfied with the outcome of the grievance/complaint the party may submit the grievance or complaint in writing to the Board of Directors for review and a response. Grievances should be addressed to Alzheimer’s Services of the Capital Area Board of Directors, ATTN: Board Secretary, 3772 North Blvd., Baton Rouge, LA 70806 or by calling any member of the Executive Committee listed on the website for an alternate address. The current Board Secretary Ms. Cindy Amedee, Phone 225.381.0279

4. Files and records of grievances/complaints shall be maintained. All grievances/complaints shall be confidential.

*I am aware of and understand my rights and the grievance/complaint procedure for clients in the Alzheimer’s Services of the Capital Area Respite Center. I hereby verify that I received a copy of the Grievance/Complaint Procedure.*

__________________________________                              __________________
Client/Legal Guardian Signature                              Date

__________________________________                              __________________
Witness: Respite Center Coordinator                              Date
Dear Caregiver:

Charlie’s Place Respite Center is a unique environment of respite care for Alzheimer’s and memory related dementia affected individuals. As such we partner with several higher education institutions and professional schools including but not limited to LSU, Southern University, Southeastern University, Our Lady of the Lake College, Baton Rouge Community College, Camelot College and Virginia College. Students from these schools participate in observation and engage in the care program to learn best-practice methods of care in the social model respite program.

The research done is very important and provides evidence-based data to support advancing care in the dementia arena.

Additionally, the organization is involved in active research programs and projects with doctoral candidates. The candidates conduct a variety of research studies through observation of the clients at Charlie’s Place. Clients of Charlie’s Place Respite Center can only be included in these observations with the consent of the client if he or she is able to consent or consent of the caregiver. The observations will not intrude on the client in any way. Participation is voluntary and clients are not identified by name. It is not our intent to burden caregivers with additional consent forms with each observational study done.

The attached consent form gives Alzheimer’s Services and Charlie’s Place Respite Center consent for ongoing and new observational studies at Charlie’s Place to be conducted. Information will be sent to notify caregivers of specific studies and identify the doctoral candidate and institute involved but new consent forms will not be required and caregivers may have the option to submit a request for a client to be omitted from a specific study. This form has been approved by an Independent Research Board that ensures it meets current consent standards.

Occasionally research projects will also involve the caregivers. Participation for the caregivers is voluntarily and will always be requested before a project is begun. We encourage you to consent to observational studies conducted at Charlie’s Place Respite Center.

Respectfully,

Barbara W. Auten                         Dana Territo  
Executive Director                      Director of Services
Alzheimer’s Services of the Capital Area
Charlie’s Place Respite Center Consent Form

Project(s) Observational Studies at Charlie’s Place Respite Center - ongoing and new research studies that involve one or more doctoral candidate (and/or students assigned to the candidate) observing clients (care recipients) during normal activities, programs, and social interaction at Charlie’s Place Respite Center.

Performance Site:
Charlie’s Place Respite Center, Alzheimer’s Services of the Capital Area, 3772 North Blvd., Baton Rouge, LA 70806

Researcher and Overseer at Charlie’s Place:
Caregivers will be notified of individual researchers, the research involved, and the duration of the study period in advance of the study. Participation is voluntary and a window of opportunity to withdraw from participation will be provided. The following Alzheimer’s Services staff members are available for questions: Barbara Auten, Executive Director and Dana Territo, Director of Services, phone 225.334.7494.

Purpose of Study:
The research projects may have a variety of purposes in advancing the knowledge and care provided to Alzheimer’s and memory-related dementia affected individuals.

Inclusion Criteria:
Voluntary participation of Charlie’s Place Respite Center enrolled clients (care recipients).

Exclusion Criteria:
Specific criteria for specific research projects may exclude clients (care recipients) at Charlie’s Place dependent on the research being done.

Benefits of the Research Project:
Results of research projects will be shared with caregivers and may be published in professional journals and web-based media.

Risks of the Research Project:
There are no known risks.

Right to Refuse:
Participation is voluntary. Alzheimer’s Services of the Capital Area and Charlie’s Place Respite Center respects the right of caregivers and clients (care recipients) to elect not to participate in observational studies. At any time, you may contact Barbara Auten to withdraw consent without penalty or loss of any benefit to which she/he might otherwise be entitled.
Privacy:
Identifying information of each participant in research projects will be kept confidential by Alzheimer’s Services and Charlie’s Place Respite Center staff. No names or other identifying information will be included in any public disclosure of results from research projects. Participant identity will remain confidential unless disclosure is required by law.

Financial Information:
There is no financial compensation for observational studies. Occasionally studies are funded and stipends are offered for participation. Caregivers will be notified of compensation in advance for a client (care recipient) participation in the study.

Please see final page for signature(s) of consent.
Signature: Please read below and if you agree, provide your signature and date
Additional questions may be directed to Barbara Auten or Dana Territo at Alzheimer’s Services. If I have questions about client’s(care recipient’s) rights or other concerns, I can contact the affiliated Review Board that can be provided by Alzheimer’s Services staff.

I _____________________________, agree to participate in observational research studies conducted at Charlie’s Place Respite Center with a signed copy of this consent form.

Client NAME or Signature: _______________________________ Date: __________________

I will allow _____________________________, client/care recipient enrolled in Charlie’s Place Respite Center to participate in observational research studies conducted at Charlie’s Place Respite Center with a signed copy of this consent form.

Caregiver’s Signature: _____________________________ Date: __________________

Please return to Alzheimer’s Services of the Capital Area, 3772 North Blvd., Baton Rouge, LA 70806
Client’s Name: ___________________________ Date: ________________

Please list all current medications, prescription and over-the-counter.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Reason</th>
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I/we, the undersigned, do hereby agree to participate in the programming of the Alzheimer’s Services of the Capital Respite Center.

I/we, the undersigned, do hereby expressly remiss, release, and forever discharge the Alzheimer’s Services of the Capital Area Respite Center and all of its administrators, other employees, acting officially or otherwise, from any and all claims, demands, actions, or causes of action, on account of death, or on account of injury to the undersigned, my/our heirs or assigns, which may occur as a result of or as a result from said services and duties to be performed by Alzheimer’s Services of the Capital Area Respite Center.

I/we understand that the Alzheimer’s Services of the Capital Area Respite Center, will re-evaluate clients every 6-8 weeks to determine ability to participate programming. I understand that my participation in the Alzheimer’s Services of the Capital Area Respite Center could be DISCONTINUED if my circumstances change.

______________________________________________  ______________________________________
Client/Legal Guardian Signature                  Date

______________________________________________  ______________________________________
Respite Center Coordinator                      Date
Release Form

Photography/Video

Client Name: ______________________________________________________________________________

I hereby give to Alzheimer’s Services, its nominees, agents and assigns, my free and unlimited consent and permission, waiving all claims for any compensation by reason thereof or for damages by reason thereof, to use, publish/broadcast, republish/rebroadcast or exhibit in the furtherance of its work, with or without identification of me by name, the photograph/video described below:

Alzheimer’s Services and Charlie’s Place Promotional Photography

and to disseminate statements referring to me in conjunction therewith if Alzheimer’s Services so desires and to authorize any media, company or organization to use, publish/broadcast or exhibit said photograph/video with or without identification of me by name and to publish/rebroadcast or disseminate statements referring to me in conjunction therewith in the promotion of Alzheimer’s Services and any of its fundraising campaigns or any of its clients.

Signature: ___________________________________________________________________________________

Caregiver Name: _____________________________________________________________________________
(Please Print)

Address: _____________________________________________________________________________________
(Home)

Charlie’s Place Tours Permission

I hereby give to Alzheimer’s Services, its nominees, agents and assigns, my free and unlimited consent and permission, waiving all claims for any compensation by reason thereof or for damages by reason thereof, to allow periodic tours/visitations of Charlie’s Place by potential Charlie’s Place clients and their caregivers, family members, and/or media promootors during normal operating hours of the Center.

Caregiver Signature: ___________________________________________________________________________
The Respite Center
Permission to Obtain Emergency Medical Care

I authorize Alzheimer’s Services of the Capital Area/Charlie’s Place to seek emergency medical care for ______________________ while he/she is in attendance at Alzheimer’s Services of the Capital Area Respite Center. If 911 is summoned the hospital of choice is ______________________

Physician __________________________ Phone Number ________________

Client or Representative Signature: _____________________________________

Client Name (Please Print): ___________________________________________

Address: __________________________________________________________

Witnessed by: ______________________________________________________ Signature of Witness

Date: _______________________


The Respite Center
Physician’s Statement

(For the Caregiver: Please only complete the Client’s Name, Date of Birth, Physician Name, and Fax Number. We will send the statement to the physician from our office, if you do not have a physician statement already. Thank you.)

Thank you for completing this form for your patient who is applying to attend the Alzheimer’s Services Respite Center or has applied for Respite Reimbursement Program. The Respite Center is a social program; medical care is not provided. Lunch and snacks will be served. For more information, contact Alzheimer’s Services (225) 334-7494.

Client’s Name: ___________________________ DOB: ___________________________

Physician’s Name: ______________________ Fax Number: ______________________

**Diagnosis** (check one):
- ☐ Dementia
- ☐ Alzheimer’s disease
- ☐ Pick’s disease
- ☐ Mild Cognitive Impairment
- ☐ Other related disorder: ___________________________________________________

Allergies: ____________________________________________________________________

Diet: ________________________________________________________________________

____________________________________________________________________________

Physician’s Signature                        Date

Please fax this form to Alzheimer’s Services at (225) 387-3664. Or mail to: Alzheimer’s Services, 3772 North Blvd., Baton Rouge, LA 70806.
Member enrollment

Last name
First name
Nickname
Address (no PO Box)
City
State ZIP code
Phone ( )
Birth date Male Female
Last 4 digits of Social Security No.
Height Weight
Eye color Hair color
Race/ethnicity Dark Medium Fair
Mole Tattoo Scar Birth mark

Medical conditions
Only individuals with Alzheimer's or a related dementia are eligible for the MedAlert + Safe Return program.

☐ Alzheimer's disease
☐ Other dementia

Other conditions
☐ Angina
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Hearing Impaired
☐ Hypertension
☐ Myocardial Infarction
☐ Organ Transplant
☐ Seizure Disorder
☐ Stroke
☐ Von Willebrand's Disease

Other
☐ Implant*

Primary contact information

Last name
First name
Address (no PO Box)
City
State ZIP code
Phone home ( )
Cell ( )
Work ( )
Email

Optional $35 caregiver enrollment

Medications
List all medications and dosages, including inhalers.

Medication Prescribed Dosage

Medical conditions
Check the box next to each of your conditions and write in any others. While these conditions are very important, any condition that requires continued physician care or special attention in an emergency should be noted.

☐ Angina
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Hearing Impaired
☐ Hypertension
☐ Myocardial Infarction
☐ Organ Transplant
☐ Seizure Disorder
☐ Stroke
☐ Von Willebrand’s Disease

Other
☐ Implant*
☐ No known medical conditions

Emergency contact

Last name
First name
Nickname
Phone home ( )
Cell ( )
Work ( )

Drug allergies
List all known drug allergies.

* Please list the manufacturer model and serial number, or include a copy of your implant card with this form.
THE MEDICALERT -- SAFE RETURN PROGRAM OF ALZHEIMER'S SERVICES IS PROVIDED THROUGH A TRIBUTE GIFT MADE BY BILL ATCHISON IN HONOR OF JEANNE ATCHISON

Member ID jewelry & payment

Select your ID jewelry included in your membership

Products are shipped to the primary caregiver unless otherwise requested.

Measure wrist for ID bracelet

Use a flexible tape measure to determine wrist size, or wrap a string around your wrist and measure it against the ruler on the side of this page.

Front of jewelry

2101 Stainless steel large emblem, purple logo w/ bracelet (not pictured)
2102 Stainless steel small emblem, purple logo w/ bracelet

2100 Stainless steel round pendant, purple logo

Back of jewelry

Other products are available online at medicalert.org/safereturn.

Emblem engraving

In an emergency, response personnel need to be aware of your loved one's critical medical information in order to treat them correctly. Their Med Alert + Safe Return jewelry will be engraved with their member ID number and our 24-hour emergency response number to enable responders to assist your loved one immediately. To help ensure you receive thorough, accurate treatment, the condition our trained staff deems most relevant to your medical needs in an immediate emergency treatment will be engraved on the jewelry.

Please note: Once your jewelry has been engraved and shipped, there will be an additional charge for any changes requested. Jewelry engraving is personalized to individual members and cannot be transferred to another individual, altered, sold or returned.

Member jewelry selection

Type □ Small stainless steel bracelet (1/4") □ Large stainless steel bracelet (1/4") □ Stainless steel pendant (1/4") with necklace (26” chain)

Exact wrist measurement ______ inches
(Required for bracelet. Please measure wrist snugly and add 1/4”)

Caregiver jewelry selection (if purchasing caregiver membership)

Type □ Small stainless steel bracelet (1/4") □ Large stainless steel bracelet (1/4") □ Stainless steel pendant (1/4") with necklace (26” chain)

Exact wrist measurement ______ inches
(Required for bracelet. Please measure wrist snugly and add 1/4”)

Consent

Important: By accepting membership in Med Alert Foundation, for yourself as member or caregiver and/or as caregiver on behalf of the member named above (collectively, "you"), you authorize Med Alert to release all medical and other confidential information about you in emergencies and to other health care personnel you designate. If you choose to terminate membership, you must notify us in writing and return your jewelry. Med Alert relies upon the accuracy of the information that you provide. You, therefore, agree to defend, indemnify, and hold Med Alert (including its employees, officers, directors, agents, and organizations with which it maintains a marketing alliance for the provision of services hereunder) harmless from any claim or lawsuit brought by member or others for injury, death, loss or damages arising in whole or in part out of your provision of incomplete or inaccurate information to Med Alert. Furthermore, as caregiver for the member named above, you hereby represent and warrant to Med Alert that you have full power and authority, as the duly authorized representative of such member, to enroll and act on his or her behalf.

Signature

Recent photo of member provided?

□ Yes □ No

Send original photo, passport size or larger. Photo will not be returned. Please write member's name on back of photo.

Cost

One time enrollment fee $55
Optional caregiver membership and jewelry ($35)
Shipping and handling $7
Total $________

$35 annual renewal fee

When annual fee is due, I authorize the $35 charge to my designated account listed below:

□ Yes □ No

Payment

□ Check (made payable to Med Alert Foundation)
□ Visa® □ Mastercard®
□ American Express® □ Discover®

Card number ________
Expiration date ________
Cardholder's name: ___________
Cardholder's signature: ___________