Charlie's PLACE
The Alzheimer's Services Respite Center

Dear Family,

Thank you for your interest in Charlie's Place, our award-winning Respite Center specially designed for individuals with Alzheimer's disease and/or related dementia disorders.

On behalf of the staff , I would like to welcome you and your loved one to Charlie's Place. An admission packet is enclosed for you, and once these forms are completed, you may call Dedrick Welch, the Respite Center Coordinator, or me and we can set up an evaluation on your loved one.

Again, I am happy to welcome you to Charlie's Place. If I can be of further assistance to you, please do not hesitate to contact me.

Sincerely,

Treasure White
Director of Respite

3772 NORTH BOULEVARD, BATON ROUGE, LOUISIANA 70806
PHONE 225.334.7494 TOLL 1.800.548.1211 FAX 225.387.3664
EMAIL services@alzbr.org WEBSITE www.alzbr.org

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

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 disorder, including statement from physician of diet (i.e. regular, diabetic, etc.)

- Admissions Paperwork including
  - Admissions Application
  - Signed Confidentiality Statement
  - Emergency Medical Care
  - Physician's Statement (includes diagnosis, diet, allergies)
  - Medications Profile
  - Emergency Contact Form
  - Consent/Waiver to Participate in Program
  - Louisiana Independent Living Assessment (Green form for EBR Council on Aging Congregate Meals Program)
  - Safe Return Enrollment Form
  - Grievance/Complaint Procedure
  - Photography/Video Release
  - Mini Mental Status Exam administered by Alzheimer's Services
  - Areas of Interest Profile completed at MMSE evaluation
  - Care Plan Form
  - Respite Reimbursement Funding Guidelines
  - Financial Responsibility
  - IRB Form

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.**

Alzheimer's SERVICES of the Capital Area | Charlie's PLACE

The Respite Center
Fee Schedule

Effective April 2019:

Cost of the Program

The Alzheimer's Services Respite Center fees are listed below and include:

- Activities and supplies
- All meals and snacks

- Clients at Charlie's Place are invoiced at the end of the month for that month's services. Billing is invoiced monthly.

  Ex.: June 30th – billed for number of days attended in the month of June, including absentee fees

- **The new fees structure will be as follows:**

  $ 65 per day
  $ 25 per day – absentee fee (client may makeup day(s) missed, depending on availability. Makeup days must be coordinated by the Respite Center Coordinator)

Charlie's Place Method of Billing

If your loved one misses a day due to illness or a vacation you may schedule a make-up day or days based on availability of the week. Please contact the Respite Center Coordinator to notify him/her of changes.

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

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

Alzheimer's SERVICES of the Capital Area Charlie's PLACE

The Respite Center

Today's Date: _____

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
☐African-American
☐American Indian or Alaska Native
(principal tribe_____)
☐Asian (race:_____)
☐Pacific Islander (race: _____)

Caregiver's Fluent languages:
☐English ☐Spanish ☐French ☐Other: _____

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

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

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:_____

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
☐African-American
☐American Indian or Alaska Native
(principal tribe _____)
☐Asian (race:_____)
☐Pacific Islander (race: _____)

Client's Fluent languages:
☐English
☐Spanish
☐French
☐Other, list: _____

Physician's diagnosis (select one)
☐Dementia
☐Alzheimer Disease
☐Pick's Disease
☐Mild Cognitive Impairment
☐Lewy Body Dementia
☐Vascular
☐Frontal Temporal Lobe Dementia
☐Parkinson's
☐Other related disorder,
explain_____
☐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**	☐**Stage II: Moderate**	☐**Stage III: Severe**
Repeating themselves	Confused about recent events	Inability to understand words
Getting lost in familiar places	Not recognizing self in mirror	Difficulty with simple tasks
Losing interest in hobbies	Not recognizing family	Arguing frequently
Forgetting common items	Unable to care for self	Believing things are real that are not
Losing things more often	Anxiety and/or depression	Repetitive actions or speech
Personality change		

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?

	Needs no help/supervision	Needs some help/occasional supervision	Needs a lot of help/constant supervision	Can't do it at all
Eating	☐	☐	☐	☐
Getting in and out of bed	☐	☐	☐	☐
Getting around inside	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐
Doing heavy housework	☐	☐	☐	☐
Doing light housework	☐	☐	☐	☐
Doing laundry	☐	☐	☐	☐

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:

	hours per week
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.

Is the client manageable for you at home at this time? ☐Yes ☐No

---

At home, does the client/elder have problems with:

a. sleep patterns: ☐Yes ☐No

---

b. eating habits: ☐Yes ☐No

---

c. mobility: ☐Yes ☐No

---

d. wandering: ☐Yes ☐No

---

e. incontinence: ☐Yes ☐No

---

f. level of anxiety: ☐Yes ☐No

---

g. level of cooperation: ☐Yes ☐No

---

h. level of contentment: ☐Yes ☐No

---

i. expressions of happiness: ☐Yes ☐No

---

j. other (e.g., change in medication): ☐Yes ☐No

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.

	None of the time	Some of the time	All of the time
Loneliness	1	2	3
Helplessness	1	2	3
Boredom	1	2	3

Client Health and Demographic Information

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

☐None ☐arthritis
☐diabetes ☐hypertension
☐heart disease ☐other _____

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

☐none ☐4 to 6
☐1 to 3 ☐over 6

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

☐none ☐4 to 6
☐1 to 3 ☐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 ☐Sulfa ☐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:

	No Interest	A little	A great deal
Incontinence care	1	2	3
Adaptive equipment (clothing, special utensils, etc)	1	2	3
Nutrition and dietary concerns	1	2	3
Managing problem behavior	1	2	3
Other _____	1	2	3

LOUISIANA DEPARTMENT OF HEALTH

Authorization to Release or Obtain Health Information For Eligibility in Program Enrollment

(including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid ID# or Social Security #:

I authorize:

Name: Alzheimer's Services of the Capital Area/Charlie's Place

Mailing Address: 3772 North Boulevard

City, State, Zip Code: Baton Rouge, LA 70806 Phone #: 225-334-7494

❒ **To Release Information TO** **OR** ☒ **To Obtain Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.

Name: (Physician's Name) _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: Physician Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below *(Place an "X" in the box(es) that apply.)*

❒ Eligiblity Determination

❒ Other: (Specify) _____

I authorize the release of the following protected health information.

(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)

❒ Entire Record ☒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests

❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports

❒ X-ray Reports ❒ MR/DD Reports ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

❒ Alcoholism ❒ Drug Abuse ❒ Mental Health ❒Vocational Rehabilitation ❒ HIV (AIDS)

❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes

❒ Other _____

This authorization shall expire on Date of Discharge **(date or event) and is needed for the period beginning _____and ending _____.**

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____

Signature of Individual or Personal Representative Authorized by Law Date

_____ _____

Signature of Witness *(If signed with an "X" or mark)* Date

For LDH Use When Requesting Records

I am authorized to receive this disclosure. Documentation on the above Personal Representative has been obtained.

_____ _____

Signature and Title of Agency Representative Date

Important Information about Authorization

You do not have to sign this form. If you agree to sign this authorization to release or obtain information, you will be given a signed copy of the form. If you do not agree to release of information required to determine your eligibility for enrollment in our health plan or to determine your entitlement to benefits we may not be able to make the required eligibility determinations.

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

When required by law or policy, LDH may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, LDH will use and disclose your health information as you have authorized on the signed authorization form.

You may be required to sign an authorization before receiving research-related treatment.

You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor by LDH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to LDH.

You may cancel an authorization in writing at any time. LDH can not take back any uses or disclosures already made before an authorization was cancelled.

Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by LDH privacy policies.

Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how LDH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. LDH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

State of Louisiana
Louisiana Department of Health

INSERT PROGRAM OFFICE INFORMATION HERE INCLUDING EMAIL ADDRESS

Phone: ( )
E-mail : Privacy-LDH@la.gov

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

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. I authorize Alzheimer's Services Staff to give permission for my loved one to be transported to my hospital of choice. 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: _____

Alzheimer's SERVICES of the Capital Area Charlie's PLACE

The Respite Center
Physician's Statement

(For the Caregiver: <u>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</u>.)

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: _____
☐Lewy Bodies
☐Vascular dementia
☐Frontal Temporal Lobe dementia
☐Parkinson's

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.

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

THE RESPITE CENTER

Medication Profile

Client's Name: _____ Date: _____

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

Medication Name	Dosage	Reason

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

THE RESPITE CENTER

Emergency Contact Information

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: _____

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

The Respite Center
Participation Consent and Waiver

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

The Respite Center
Confidentiality Statement

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 crimin+al 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

June 2021

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 Respite and Training, 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 President, 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 President is James Baker

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
Executive Director

Treasure White
Director of Respite

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 Treasure White Director of Respite, 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 Treasure White 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
(client name)

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

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)

Phone: _____

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 promotors during normal operating hours of the Center.

Caregiver Signature: _____

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

Charlie's PLACE
The Alzheimer's Services Respite Center

Let Me Tell You My Story

My name is _____ and I like to be called _____.
Full Name Nickname

I was born on _____ in _____.
Birthdate City, State

_____ is the name of my partner in life, but I like to call
Full Name

him/her _____. I want you to know that my partner in life is _____
Nickname Describe

_____. We have _____ children. Our children are _____.
Number Describe

Their names are _____. Our grandchildren include
First Names

_____. We even have great
First Names

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
Activity

something really bothers me like _____. Music also helps to
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
Time

_____ and then I _____. For breakfast, my
Activity Activity

favorite food is _____. My afternoon routine includes many things
Breakfast Food Item

but one thing I do not skip is _____. I like to keep my nighttime
Activity

routine as well, which includes _____. I like to be in bed by
Activity

_____. Like everyone, I enjoy naps, usually at _____.
Time Time and Location

I never leave home without my _____. _____
Security Item Item of Clothing

_____ 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
What helps?

_____. My memory is _____, so assistance usually involves
What helps? Describe

_____. In restrooms, I need help _____. I like
What helps? What helps?

to be independent as much as possible, especially _____.
Independent Activity

To cook for me you need to know that my favorite food is _____
Favorite Food

but I cannot tolerate _____. My allergies include _____
Disliked Food Allergies

_____.

Let Me Tell You About My Family

I grew up in the _____. My parents' names were
Describe Hometown

_____ and _____ but I call them
Father Mother

_____ and _____. I have _____ siblings, their
Nickname Nickname Number

names are _____. My parents made a living by
First Names

_____.
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
City, 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

_____.

Let Me Tell You About My Interests

As I grew up, my favorite thing to do was _____. Now, my
Activity

favorite television show to watch is _____ and my favorite movie is
TV Show

_____.
Movie

I grew up playing games with _____ and we loved to play
Childhood Friend(s)

_____. But those were just for fun, it got serious in school when
Childhood Games

I played _____. My favorite activity to do inside, maybe on a
School Sport

rainy day is to _____. But if the weather is pretty I like to go
Indoor Activity

outside to _____.
Outdoor Activity

I am skilled at _____ but I am talented at
Activity

_____. When it comes to making my own music, I play
Activity

_____. Because of my interests and my skills, my hobbies
Instrument

include _____.
Hobbies

Animals to me are _____. My favorite animals are _____
Personal Opinion

_____. Pets I have owned include _____.
Animal(s) Type of Animals

My favorite pet I ever had was named _____ this one was my favorite
Type of Animal and Name

because _____.
Describe a Favorite Memory of the Favorite Animal

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

_____.
Describe the Feeling toward Education

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 _____
Important Tradition Observed

_____. I am fluent in _____.
Language(s)

My spirituality is a _____ part of who I am. I express my spirituality daily
How Important?

by _____ and less often, yet still important to me, I always
Activity

participate in _____.
Spiritual/Religious Tradition

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

_____

_____.

MedicAlert FOUNDATION

PLEASE SEND COMPLETED FORMS TO
groups@medicalert.org or
mail to MedicAlert Foundation, PO Box 21009, Lansing, MI 48909

CODE: ALZ

MEDICALERT NEW ENROLLMENT FORM

Please complete one form for each individual enrolling.

PERSON WEARING THE MEDICAL ID
(All fields required)

LAST NAME

FIRST NAME

ADDRESS

APT# CITY

STATE ZIP

EMAIL

HOME PHONE MOBILE PHONE

BIRTHDATE (MM/DD/YYYY) LAST 4 DIGITS OF SSN

GENDER (CHECK ONE)

☐ Female ☐ Male ☐ Prefer not to say

☐ Prefer to self-describe: _____

ENROLLEE IS (CHECK ONE):

☐ Person Living With Dementia

☐ *Caregiver for: _____
MEMBER FULL NAME MEMBER DATE OF BIRTH

**NOTE: If the person you are a caregiver for is enrolled in MedicAlert, your ID will include "Caregiver for" and the member ID of that person.*

EMERGENCY CONTACT

FULL NAME

RELATIONSHIP TO ENROLLEE

MOBILE PHONE

EMAIL

ALZ CHAPTER ONLY

ALZ CHAPTER NAME

CONTACT NAME CONTACT PHONE

CONTACT EMAIL

FUNDING SOURCE (IF APPLICABLE) GRANT NAME (IF APPLICABLE)

INFORMATION FOR YOUR EMERGENCY HEALTH RECORD

MEDICAL CONDITIONS & DEVICES
For example: Alzheimer's, memory impaired, diabetes, insulin pump, pacemaker

ALLERGIES
List all known food, drug or other allergies

MEDICATIONS
List all medications and dosages, including inhalers
If more room is needed please attach a separate sheet.

WHAT DO YOU WANT ENGRAVED ON YOUR ID?
Engraving should include your most critical information. All other health data provided here will be available to first responders in your Emergency Health Profile.

Once your enrollment is processed, you'll receive an email from MedicAlert with a link to complete your full online health profile.

CHOOSE AN ID
(For more styles, visit medicalert.org)

CLASSIC STEEL BRACELET WITH COLOR - $24.99

☐ Red (A126) ☐ White (A751) ☐ Blue (A655) ☐ Black (A739) ☐ Green (A657)

☐ Pink (A658) ☐ Orange (A656) ☐ Purple (A659) ☐ Light Blue (A654)

Sizes available: 4” - 10” in ½” increments

Size needed: _____

LARGE CLASSIC STEEL BRACELET WITH COLOR $29.99

☐ Purple (A729) ☐ Red (A091) ☐ Black (A740)

Sizes available: 4” - 10” in ½” increments

Size needed: _____

CLASSIC STEEL NECKLACE WITH CURB CHAIN - $29.99

☐ Purple (A730) ☐ Red (A721) ☐ Black (A738)

Comes on a 26” or 30” curb chain

Size needed: _____

STAINLESS STEEL DOG TAG - $24.99

☐ Black/Red on 30” beaded chain (A600)
☐ Steel/Red on 30” beaded chain (A601)

SPORT SILICONE BRACELET - $24.99

☐ Black (A011) ☐ Blue (A012) ☐ Violet (A013)

☐ Pink (A014) ☐ Red (A015)

Sizes available: Sm: 5”-6”, Med: 6”-7”, Lg: 7”-8”

Size needed: _____

STRETCH BAND - $44.99

❑ Gold Tone & Steel (A704) ❑ Gold Tone (A706)

❑ Steel (A734) **- $34.99**

Sizes available: Sm: 5”-6”, Med: 6.5”-7.5”, Lg: 8”-9”

Size needed: _____

SIZING INFORMATION

It’s important your MedicAlert® emblem fits comfortably around your wrist. To determine your size, snugly wrap a tape measure around your wrist. Note the measurement, then add half an inch. This is the size MedicAlert bracelet you’ll need.

CHOOSE A MEMBERSHIP PLAN WITH 24/7 WANDERING SUPPORT (NOTE: membership plan is required)

☐ **Advantage** ($49.99/yr)

MEMBERSHIP BENEFITS:

- 24/7 Emergency Response Team
- Emergency Health Profile
- Emergency Contact Notification
- Personal Profile
- Portrait Photo (selfie)
- Printable Health Profile

☐ **Advantage Plus** ($74.99/yr)

INCLUDES ALL ADVANTAGE BENEFITS, AS WELL AS:

- Physician Notification
- Document Storage
- Advance Directive/DNR

PAYMENT

ID TOTAL _____

MEMBERSHIP TOTAL _____

SHIPPING $7.00

TOTAL _____

For your convenience & to ensure uninterrupted membership with MedicAlert, your credit card will automatically be charged for your membership on your annual renewal date.

PAYMENT TYPE

☐ Check (make payable to MedicAlert Foundation)

☐ MasterCard® ☐ Visa® ☐ Discover® ☐ AMEX®

No other cards accepted. No CODs. Payment must accompany order.

CREDIT CARD NUMBER

EXPIRATION DATE (MM/YY) SECURITY CODE

CARD HOLDER’S NAME

CARD HOLDER’S BILLING ADDRESS

CITY STATE ZIP

SIGNATURE FOR CARD AUTHORIZATION

RELEASE

Important: By accepting membership in MedicAlert Foundation, for yourself as member or caregiver and/or as caregiver on behalf of the member named above (collectively, “you”), you authorize MedicAlert to release all medical and other confidential information about you in emergencies and to other health care personnel you designate. Read the full consent at www.medicalert.org/consent.

SIGNATURE OF MEMBER OR REPRESENTATIVE DATE