

<b>Bon Homie, Ltd. Adult Day Center Application</b>			
Name		Admission Date	
Address			
Living Arrangements			
Phone #		Township	
Age		Social Security_#	
Height		Date of Birth	
Male/Female		Weight	
Color of Hair		Race	
Color of Eyes		Primary Language:	
Identifying Marks - Birth Marks, Scars, Tattoos			
<b>Caregiver Information</b>			
Name of Caregiver			
Relationship			
Caregiver's Address			
Home Phone #		Work #	
		Cell #	
Emergency Contact		Phone #	
Relationship			
Primary Physician		Phone #	
Address			
<b>MEDICAL BACKGROUND:</b>			
<b>Client Diagnosis, Disabilities, illnesses and conditions:</b>			

<b>Limitations, treatments, or special care required:</b>			
<b>Protocols- Seizure, Fall Risk, Eating Precautions:</b>			
<b>Physical Aids for mobility (helmet, walker, supervision, etc.):</b>			
<b>Health Status</b>			
<b>Medications:</b>			
<b>Contraindicated Medications:</b>			
<b>Allergies:</b>	Food:	Drug:	
<b>Physical Activities of Daily Living:</b>			
<b>Activity</b>	<b>Self-Care</b>	<b>With Assistance</b>	<b>Total Care</b>
Eating			
Bathing			
Dressing			
Toileting			
Does the clients wear an incontinence pad?		Yes	No
Mobility			

Transferring from wheelchair to toilet:								
<b>Dentures</b>	Yes		Uppers		No Teeth			
	Partials		Lowers		No Dentures			
			<b>Normal</b>		<b>Slight Difficulty</b>		<b>Moderate-Severe</b>	
Hearing								
Sight								
Speech								
<b>Communication</b>					Verbal:			
Uses sign language:					Non-Verbal:			
Does the individual wear a hearing aid?					Yes		No	
If Yes -	Left ear		Right ear		Both ears			
<b>Does the individual wear glasses?</b>					Yes		No	
<b>Intellectual Functioning (Please Check)</b>								
			<b>Always</b>		<b>Sometimes</b>		<b>Never</b>	
Able to make decisions								
Able to plan								
Understands directions								
Can Communicate Needs								
Distant memory accurate								
Recent memory accurate								
Knows Time/Date								
Knows others								
Knows place								
Knows self								
Knows danger								
Aware of Risks/Consequences								
Need for Supervision								
<b>Mental Emotional Status (Please check)</b>								
Alert		Occasionally confused			Confused			
Wanders		Social/friendly			Lonely			
Anxious/Worried		Fearful			Passive/Withdrawn			
irritable		Agitated			Easily Upset			
Depressed		Angry			Loss if interests			
Paces								

**Instrumental activities of daily living-** activities that people do once they are up, dressed, and put together. These tasks support an independent life style. Please rate individual's level in each area by checking one level for each subsection:

<b>A. Ability to use telephone</b>	
1. Operates telephone on own initiative; looks up & dials numbers, etc.	
2. Dials a few well-known numbers	
3. Answers telephone but does not dial	
4. Does not use telephone at all	
<b>B. Laundry</b>	
1. Does personal laundry completely	
2. Launders small items; rinses stocking, etc.	
3. All Laundry must be done by others	
<b>C. Shopping</b>	
1. Takes care of all shopping needs independently	
2. Shops independently for small purchases	
3. Needs to be accompanied on any shopping trip	
4. Completely unable to shop	
<b>D. Food Preparation</b>	
1. Plans, prepares, and serves adequate meals independently	
2. Prepares adequate meals if supplied with ingredients	
3. Heats, serves, or prepares meals but does not maintain an adequate diet.	
4. Needs to have meals prepared and served or receives tube feedings	
<b>E. Mode of Transportation</b>	
1. Travels independently on public transportation or drives own car	
2. Arranges own travel via taxi, but does not otherwise use public transit	
3. Travels on public transportation when accompanied by another	
4. Travel limited to taxi or automobile with assistance of another	
5. Does not travel at all	
<b>F. Housekeeping</b>	
1. Maintains house alone or with occasional assistance	
2. Performs light daily tasks such as dishwashing & bed making	
3. Performs light tasks but cannot maintain acceptable level of cleanliness	
4. Needs help with all home maintenance tasks	
5. Does not participate in any housekeeping	
<b>G. Responsibility for own medication</b>	
1. Is responsible for taking medication in correct dosages at correct time	
2. Takes responsibility if medication is prepared in advance in separate dosage	
3. Is not capable of dispensing own medication	
<b>H. Ability to Handle Finances</b>	
1. Manages financial matters independently, can collect and track income	
2. Manages day-to-day purchases, but needs help with banking & major purchases	
3. Incapable of handling money	

## Diet, Consistencies, & Textures

**Client Name:** \_\_\_\_\_ **Program:** Bon Homie Ltd.

**Diet: (Check all that apply)**

☐ NPO      ☐ House      ☐ Diabetic      ☐ Lactose Free  
☐ GERD      ☐ No Seeds      ☐ Other, please specify: \_\_\_\_\_

**Tube Feeding Orders:** Time of Feeding: \_\_\_\_\_

☐ G-Tube      ☐ J-Tube  
☐ Bolus      ☐ Gravity      ☐ Pump: Pump Type \_\_\_\_\_ Rate \_\_\_\_\_

Formula Type & Amount: \_\_\_\_\_

Flush with water- time & amount: \_\_\_\_\_

**Food Consistencies (please check only one):**

- ☐ **Regular Diet-** individual is able to cut their own food, no choking or aspiration risks  
☐ **Assisted Regular Diet-** needs assistance to cut food, no choking or aspiration risks  
☐ **Quarter-size Regular Diet-** staff must cut food prior to serving- food is less than one inch diameter, no choking or aspiration risks.  
☐ **Dime-size Regular Diet-** staff must cut food prior to serving- food is cut to ½-3/4inch diameter  
☐ **Quarter-size Soft Diet-** food is of soft/moist consistency requires some chewing, less than one inch in diameter. May add liquid to moisten.  
☐ **Dime-size Soft Diet-** food is of soft/moist consistency, requires some chewing, cut to 1/2-3/4 inch in diameter. May add liquid to moisten.  
☐ **Mechanically Chopped Soft Diet-** Food processor is used, check to ensure no large chunks, moist consistency, chopped to less than ½ inch diameter (Smaller than a raisin) and may add liquid to moisten.  
☐ **Fine/Ground Soft Diet-** Food processor used longer, crumbly/moist consistency, ground to less than 1/4-1/8 inch (size of rice or smaller), ensure no chunks, and will likely add liquid to moisten.  
☐ **Pureed, Pudding-Like Diet-** Food processor used, smooth, pudding-like, very moist consistency, ensure no chunks, strainer can be used, likely need to add liquid to moisten.

**Liquid Consistencies (Check one from Column):**

- ☐ Thin/Regular Consistency  
☐ Nectar Thick Consistency  
☐ Honey Thick Consistency  
☐ Spoon-thick/Pudding-Thick Consistency

**Fluid Restrictions:** \_\_\_\_\_ Yes/amount      \_\_\_\_\_ No

**Fluid Minimums:** \_\_\_\_\_ amount/day

**Aspiration Precautions:** \_\_\_\_\_ Yes      \_\_\_\_\_ No  
 Specific Instructions: \_\_\_\_\_

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

<b>Social Background:</b>		
Previous Occupation		
Religious Affiliation		
Children (Names and ages)		
Current Activities/Interests		
Former Activities/Interests		
Food Likes and Dislikes	Likes:	
	Dislikes:	
<b>Approximate Date Client Experienced the following:</b>		
Death of Spouse/Significant other:		
Major Illness or Injury		
Marriage/Remarriage		
Change in Residence		
Change in Household Members		
Change in Financial Status		
Retirement		
<b>Caregiver</b>		
Limitations on the caregiver:		
Problems with caregiving:		
Caregiver Burden:		
Caregiver need for support:		
<b>LIVING WILL</b>	<b>Yes-</b>	<b>No-</b>
Copy on File?	<b>Yes-</b>	<b>No-</b>
<b>POA</b>	<b>Yes-</b>	<b>No-</b>
Copy on File?	<b>Yes-</b>	<b>No-</b>
<b>Please list all services currently receiving, including frequency and agency involved:</b>		
Service	Agency	Frequency

I hereby consent to receive the services of Bon Homie, Ltd. Adult Day Center and authorize the center to obtain the necessary medical/ social information from my physician or other health care professionals.

I hereby give Bon Homie permission to release information to share limited treatment and diagnostic information with third-party payers for purpose of reimbursement and to transfer the client's records to another facility if the client transfers from the center to that facility.

Final acceptance into the program is contingent upon receipt of all information and the multi-disciplinary assessment provided by the center.

Signature and date of Applicant/Client	
Signature and date of person responsible for payment and to Bon Homie, Ltd. for services rendered.	
Address of Responsible Party	
Signature and date of Staff member reviewing forms	



## Enrollment Agreement

*Participants Name:* \_\_\_\_\_ *Date of Birth:* \_\_\_\_\_

### *Services and Goals*

#### **Services**

Our Center opens at 7:00 AM and closes at 5:30 PM - Monday thru Friday. We offer a full day and half day. A full day is considered any amount of time over four hours.

Bon Homie offers two programs to meet the needs of those we serve: Sunflower Meadows - a program structured to meet the needs of clients that are elderly and require some support with activity and personal care needs. This program also benefits adults that are disabled due to illness or accidents that require some support throughout the day. Sandpiper Haven - a program structured to meet the needs of clients with special needs and that require much more assistance with daily living activities.

We make every attempt to maintain flexibility with client schedules as long as our census allows for it.

We are staffed by professionals including Registered Nurses. They provide assessment, treatment, health screening, health education, medication administration, first aid care, respiratory treatments and other care as needed.

We serve a full nutritious lunch that is dietician approved and meets RDA requirements.

Snacks are provided in the morning and afternoon. Special diets are honored.

We do provide showers for clients at an additional cost.

Transportation is available to Montgomery and Chester County Residents if they qualify.

Fox Rehabilitation offers PT and OT services on the premises if clients qualify.

We are also a valuable referral resource for our clients and caregivers, please don't hesitate to ask.

#### **Goals of the Center:**

1.	To provide a safe, healthy and pleasant environment for the center.
2.	To communicate with the clients and families so that we may serve their every need and concern.
3.	To interact with the clients and their families on a personal basis so that we may serve their personal needs to the best of our ability.
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4.	To plan and provide an activity program that motivates clients to be involved; keeping clients' interests in mind.
5.	To take advantage of time that allows for one-on-one relationships between staff members and clients whenever available.
6.	To provide nutritious, well balanced meals. Dietitian approved.
7.	To keep employees of Bon Homie, Ltd. informed and educated of prior, up to date, and proposed regulations so that we may serve our clients and their families to the best of our ability, while staying current with our licensing agencies.
8.	To continue to contract with all county agencies in the tristate area so that we may serve all families that are in need our services and require funding support through the surrounding counties.
9.	To form relationships with other agencies that can assist our families with needs that cannot be met by the day center.
10.	To assist families in locating other facilities and programs for their loved ones when Bon Homie, Ltd. can no longer care for their loved one.

### **Activity Schedule**

7am	Center Opens
7am – 8:45am	Table Activities – Clients arriving for the day.
9am	Morning Snack
10am – 11am	AM Activity
11am	Exercise
12pm	Lunch
1:30 pm – 2:30pm	PM Activity
2:30pm	Snack
3pm – 5:30pm	Table Activities – clients begin to leave for the day.

### **Enrollment Criteria**

Bon Homie, Ltd. is a community based Adult Day Center that currently serves elderly and disabled adults over the age of eighteen with physical, psychosocial or mental impairments who require assistance throughout the day or supervision. The individual enrolling shall fall under the scope of services provided at Bon Homie. Enrollment shall not be denied to anyone because of race, color, religion – creed, disability, and ancestry, national origin – including limited English Proficiency, age or sex. Enrollment may be denied if it is felt that the individual person would endanger himself or others while attending the program or cause an undue hardship to the facility.

### **Medical Care**

A medical evaluation must be completed prior to enrollment to the program. Within three months prior to enrollment and at least annually thereafter. Medications or treatments will be administered at the center only on the order of the participant's personal physician. See Medication Administration Policy for further detail.

### **Photograph, Audio or Video Release**

Bon Homie may use a client's photographs, names, voice recordings and/or video for marketing, teaching or training materials, publicity or fundraising, website and annual yearbook. A more detailed permission slip is in the reference manual.

## Emergency Care

In the event of an emergency, personnel of the center are authorized to administer first aid or additional assistance as may be appropriate for the participant's welfare. Caregiver will be notified of the emergency. If determined an ambulance is necessary, 911 will be called. Should there be a preference for a specific hospital attempts will be made to make those arrangements if possible. Any expenses incurred in an emergency situation will be the responsibility of the participant and or the participant's caregiver.

In the event of illness not requiring emergency care, the caregiver or emergency contact person will be notified to make arrangements for the client to be picked up.

## Discharge Policy

Provisions requiring discharge from Bon Homie, Ltd. when one or more of the following apply:

- A client does not have a functional impairment.
- A client is not capable of being transported to the center.
- A client is not in need of the structured program of activities or services provided in the center.
- Clients' needs exceed the resources of the center.
- A client cannot be retained.
- A client or responsible party notifies the center orally or in writing of intent to discontinue participation.
- Clients becomes a danger to self or others.
- Failure to meet obligations, both financial and documentation.

When discharge is initiated by the center, the center will give oral and written notification to the client or responsible party, or both, at least 30 days in advance of the impending discharge.

A client who experiences a sudden change in the level of functioning which, as determined by the center, poses a threat to the client or others may be discharged from the center immediately.

Bon Homie will assist client/caregiver in finding resources that would be more appropriate for the individual.

## Billing for Services

Billing is sent out at the end of each month for that month. If you need to cancel a scheduled day, we ask that you call and let us know the day before. If this is not possible, then please no later than 8 o' clock of the day being canceled. **If you do not cancel by 8am, you will be billed for the day.**

There is a late fee policy. For caregivers who pick a client up after 5:30 PM they will be charged an additional \$5.00 per fifteen minutes late. This charge will help in the cost of paying staff overtime. If lateness becomes a habit alternate arrangements will have to be made to resolve the problem.

Our staffing levels, activity plans and food preparation are all tailored to meet the planned client census. Your continued assistance in helping to make optimum use of our resources will enable us to continue to provide a high level of care and service at a reasonable price. With your cooperation, Bon Homie, Ltd. can continue to provide the most cost effective, stimulating and compassionate care you can provide for a loved one.

The following rate structure reflects the level of care needed for individual clients:

\$70.00 full day w/ lunch – level 1  
\$50.00 half day w / lunch – level 1

\$80.00 full day w / lunch - Level 2

\$60.00 half day w / lunch - Level 2

Level three reflects the level of care needed for an individual requiring a 1:1 - 1 to 3 ratio. May be due to dementia, or behavior issues.

\$18.00/hour - includes lunch and snacks.

These rates reflect the staff commitment and facilities resources required for each level:

Level 1 individuals require supervision and support with personal care and activities. They may require the following:

- Guard assist while walking
- Assistance getting up out of a chair and transferring
- Minimal Support with activities
- Staff supervision in the bathroom

Level 2 individuals require hands on support in most areas. They may require the following:

- Assistance with eating; making sure they do not eat too quickly, are drinking in between bites of food.
- Support while walking
- Support with activities; may include some hand over hand assistance at times.
- Supervision due to seizure disorder and wandering.
- Assistance when using the bathroom.

Level 3 individuals require total support in most areas. They may require the following:

- Require staff to feed them or are tube Fed
- Hand over hand support with activities.
- Two staff members to toilet or diaper.
- Wheelchair bound – requires lifting and transferring.
- Behavioral concerns. Dementia – wandering. May have difficulty being in a large group activity due to the noise level. May display Self-Injurious Behavior on occasion and need redirection

Rate determination will take place during the application process. Other services offered at an additional cost:

Shower - \$20.00

Hairdressing Services (paper is distributed every 4-6 weeks to sign up when she is scheduled to come.

Physical and Occupational Therapy through Fox Rehabilitation.

## **Send - Prior to or on the First Day**

1. If medications are to be given at the center: Medications need to be in the original container(s), including name of the medication, directions for administration, date of prescription, name of physician. Supply can be for one week or one month.
2. A change of clothes that is marked and can be left at the center.

## **Non-Discrimination**

Admission, the provision of services and referrals of clients are made without regard to race, color, religious creed, Disability, ancestry, national origin (including limited English proficiency), age or sex. See Non-Discrimination policy for more detail.

## **Records**

Records that pertain our client information is kept confidential. The client or the caregiver may refuse The release of records to any person outside the center, except as may be required by law or third-party payment contract. The client or responsible party will have access to the participant's own record and to the information in those records.

All records are secure and locked up when not in use.

## **Rules and Regulations**

Bon Homie, Ltd. believes in a friendly atmosphere with mutual respect for clients, their family as well as the employees of the center. To keep a home like environment, Bon Homie, Ltd. would like to introduce the rules in which they would like everyone to adhere to.

- \*Client will respect the property of other clients and of the facility.
- \*Clients will refrain from disruptive behavior. All clients will be encouraged to participate in activities but it will not be mandated.
- \*Clients will not venture outside appropriate areas unless accompanied by a staff member.
- \*Clients will not use kitchen equipment or utensils without permission.
- \*Clients will not be admitted to the facility unless all papers are signed and the Physical is completed.
- "Clients are responsible for their own belongings.
- \*Staff will assist clients in all areas necessary.
- \*Disruptive behavior will not be tolerated and will result in discharge.
- "Smoking is not permitted by any client that attends our program.

## **Liability Policy**

I/We will not hold Bon Homie, Ltd. Adult Day Services responsible for any money, valuables, or personal effects brought by the participant or relatives unless delivered personally to the Director for safekeeping.

Bon Homie will replace property that was lost or damaged, or pay the participant the replacement value for the lost or damaged item if confirmed by the provider, licensing agency or licensing agencies designee through a review of the circumstances that a participant's personal property was lost or damaged by the provider while providing service to the participant.

I/We will not hold the center responsible for the dentures, eyeglasses or any other corrective medical or prosthetic device of the participant.

I/We release anyone employed or affiliated with the Bon Homie, Ltd. Adult Day Services from any responsibility in the event of any personal loss, injury, or disability sustained by me while enrolled in the adult day program.

### **Bon Homie Ltd. Civil Rights Policies**

Nondiscrimination in the provision of services, admissions, placements, facility usage, referrals and communications with clients who are nonverbal or non-English speaking.

Physical accessibility and accommodation as needed for clients with physical disabilities.

The right to lodge civil rights complaints.

Information on these rights and the procedure for lodging civil rights complaints.

### **Grievance Procedure**

The Center's grievance procedure is reviewed with the client and caregiver during the enrollment process and also yearly at their ISP meeting. If the participant is dissatisfied with the care plan or services provided by the center, the participant may use the grievance procedure. The Client will be given a copy of their rights and they will be reviewed with the client.

### **Transportation**

Transportation is provided by the caregiver, group home, life sharing, TransNet and Rover. Staff can assist with arranging transportation through TransNet. Bon Homie is not affiliated in anyway with TransNet or Rover and has no control over the operation of these services. Clients that utilize their services must adhere to the policies established by each transportation service.

The center does have a pick up and drop off policy that the client and/or caregiver is asked to follow. They will receive a copy of this policy.

### **Termination of this Agreement**

The client or caregiver may terminate the agreement. The client and caregiver shall remain responsible for all charges incurred in connection with the participant's participation at the center until actual discontinuance of participation occurs.

### **Agreement**

I have read the agreement and all my questions have been answered to my satisfaction. I hereby certify that the enrollment agreement has been explained to me and that I have received a copy. I understand by signing below, I consent to the terms of the Enrollment Agreement, accept financial responsibility for participation in the program, and authorize the center to provide care and services.

### **Emergency Medical Care Authorization**

While visiting and/or participating in the Adult Day Center, I hereby authorize the following procedures in case of medical emergency and take full responsibility for any expenses incurred.

## Emergency Medical Care Authorization

While visiting and/or participating in the Adult Day Center, I hereby authorize the following procedures in case of medical emergency and take full responsibility for any expenses incurred. Arrange for emergency transportation, Contact family or person responsible for participant and Contact personal/ attending physician.

Hospital Preference	
Contact Name	
Relationship	
Phone Number	
Contact Name	
Relationship	
Phone Number	

## Weather and Emergency Closing Contact Information

Responsible Party	
Phone Number:	
Back Up #1	
Phone Number:	
Back Up #2	
Phone Number :	

### How did you find out about our services?

Participant Signature: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_

Is this person the Power of Attorney                      Yes (documentation is required)                      No

Relationship to Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Program Director/Administrator signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Copy given to Responsible Party \_\_\_\_\_ Staff Initials: \_\_\_\_\_ Date: \_\_\_\_\_