Welcome *Joe's Club*!

We look forward to having you join the party!

Please note: All pages must be completed, and signed by the POA (if applicable)

Please also include the following (if applicable)

☐ Do Not Resuscitate (DNR) Form

☐ Power of Attorney (POA) or other legal paperwork

If you have any questions, don't hesistate to call: 321-253-4430

ADMISSION AGREEMENT

Club member's Name: _____

I, _____ and Brevard Alzheimer's Foundation Inc.'s (BAFI) representative, agree to the following terms and conditions for the admission of the above named member to JOE'S CLUB.

I agree to complete all required forms prior to the admission of the above named Club Member. I agree that my doctor will certify that the club member is free of communicable tuberculosis and other communicable diseases on the physician's order form prior to admission.

I acknowledge that BAFI has the right to discharge the Club Member should they no longer meet the Club's criteria as outlined in the Discharge Criteria Form.

RATES AND FEES

Daily Rate	Half Day Rate	Showers	Transportation	Late Pick-up Fees
$63	$47	$18 each	$10 each way	$25
Int._____	Int. _____	Int. _____	Int. _____	Int. _____

First month's fee due on admission. Subsequent months will be billed through the secured electronic payment method chosen by financially responsible party on the 1st of each month. If payment is not received by the 7th of each month, the account will be placed on hold. Checks returned for insufficient funds will be charged a $35.00 service fee. Late pick up fees will be charged after 5:35 p.m. If you are going to be late please call and notify BAFI staff as soon as possible. Hours of operation are Monday-Friday 7:15 am to 5:30 pm.
Half day rate is for up to 4 hours. There is a grace period of 22 minutes. After this, full day rate applies.

Rates are subject to change upon a 30-day written notice to the responsible party.
Any hospitalization or leave of absence from THE CLUB in excess of forty-five days requires a re-evaluation process and new physician orders.

I will not hold BAFI or any related or supporting organization responsible for any injury arising out of my negligence or omission, during the course of the program.

All services, benefits and facilities are provided without regard to race, color, national origin, sex, age, religion or disability.

Revised 8/08/2017

Brevard Alzheimer's Foundation
4676 N Wickham Road
Melbourne, FL 32935
(321)253-4430

Secure Payment Authorization Form

Schedule your payment to be automatically charged to your Checking Account (ACH), Visa, MasterCard or Discover Card. Just complete and sign this form to get started!

Secure Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Secure Payments Work:
You authorize regularly scheduled charges to your or credit card or checking account. You will be charged the first of the month for the previous month's services. A receipt for each payment will be mailed / emailed to you and the charge will appear on your statement as an "Brevard Alzheimer's Foundation" You agree that no prior-notification will be provided.

Please complete the information below:

☐ Credit Card on file **or** ☐ Voided Check on file Client Name: _____

I _____ authorize Brevard Alzheimer's to charge my secure method
(full name)
indicated below monthly for appropriate daycare attendance and related fees.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Please fill our below Credit Card information or staple a voided check

☐ Visa ☐ MasterCard ☐ Discover ☐ Amer. Express

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Brevard Alzheimer's Foundation in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. In the case of an CC Transaction being rejected I understand that Brevard Alzheimer's Foundation may at its discretion attempt to process the charge again within 30 days. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

The Privacy Act of 1974, 5 USC 552a, provides protection to individuals by ensuring that personal information collected is limited to that which is legally authorized and necessary and is maintained in a manner which precludes unwarranted intrusions upon individual privacy.

The financial agreement is as follows:

_____
_____
_____

I have received a copy of the Notice of Privacy Practices (the "Notice"). The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (321) 253-4430, or by requesting one at:

Brevard Alzheimer Foundation's Administrative Office
4676 North Wickham Road
Melbourne, FL 32935

The undersigned has acknowledged that he/she has received the Family Resource Handbook, which includes the following documents: Code of Ethics, Grievance Procedures and Discharge Criteria.

This agreement may be terminated by the request of the responsible party or in writing by the BAFI representative. Fifteen days notice must be given by BAFI except in cases of emergency.

Name of Caregiver/Responsible Party: _____

_____ _____
Signature: Caregiver/Responsible Party Signature: BAFI REPRESENTATIVE

_____ _____
Date Date

_____ _____
Date of Termination Requested By

Reason: _____
_____
_____
_____

Billing Information: <u>All Spaces MUST be filled out</u>

Responsible Party: _____ Relationship: _____

Address: _____ City: _____ State: _____Zip: _____

Phone Day: (_____)_____Work: (_____)_____Cell: (_____)_____

Email: _____

Revised 1/24/2017

Club Member Social History Assessment

Full Name: _____

Raised in what area/state: _____

If college graduate, which school/university: _____

Military service: Yes No Which branch: Army Navy Coast guard Air force Marine corp

Primary language: _____ Other languages spoken: _____

Relligious preference: _____

Previous occupations: _____

Family Information

Spouse name: _____

How long married: _____ If deceased, when? _____

Children's names: (please include nicknames, ages, special relationships to club member)

_____

_____

_____

Pets (please include a photo if possible): _____

Hobbies, activities, sports, gifts, talents:

Past Present

_____

_____

_____

List five of the club member's favorite places to go (both past and present):

Past Present

1. _____
2. _____
3. _____
4. _____
5. _____

List any group affiliations/memberships (past and present):

Past Present

_____
_____
_____
_____

Significant achievements (prizes, awards):

_____
_____
_____
_____

Additional information:

_____
_____
_____
_____

Name of Responsible Party:_____

Signature: _____Date: _____

BAFI: _____Date: _____

Revised: 1/23/2017

AUTHORIZATION FOR RELEASE OF INFORMATION

I. I, _____, hereby give my consent to release to the Brevard Alzheimer's Foundation, Inc. (hereafter referred to as BAFI):

A. Any and all information concerning my physical condition, treatment rendered, medical and hospital records, or any other material or information related to my medical history.

B. Any and all social information related to me.

C. Authorization is further granted to BAFI to allow them to release information to other agencies or persons deemed necessary by them in order to arrange services for me in The Club.

II. I understand data gathered as a result of being at The Club will be used in reporting, research and program monitoring but my name will not be used.

I also understand that by signing this form:

A. I may be considered for this program, but refusal to either sign the release form or submit needed information may make it difficult to arrange services to help me.

B. If I believe I have been denied program services, or if information is wrongly used, I am entitled to a fair hearing.

C. I have the right to inspect my own records and can contest their validity, add data or request deletion of parts.

Name: _____

Signature:_____ Date: _____
(Client or legal guardian)

BAFI: _____ Date: _____

Revised: 1/23/2017

CONSENT FORM FOR MEMBER

_____

Name of Member

TREATMENT

I do hereby authorize and consent to medical treatment to include first aid provided by the nursing staff of The Club for minor injuries and for the Administration of prescribed medications for above named member, the Club Member taking part in The Club's Adult Day Center Program**.**

EMERGENCY TREATMENT/TRANSPORTATION

I do hereby authorize emergency treatment at, and transportation to, the nearest hospital in the event a family member or responsible party cannot be contacted, while the Club Member named above is taking part at The Club Adult Day Center Program.

Hospital of Choice, although not guaranteed, is: _____

PHOTO RELEASE

I hereby authorize The Club at Brevard Alzheimer's Foundation Inc. to use:

photographs

video and audio recordings

of the above mentioned individual; to be used for identification purposes, promotional material, and website content. I hereby release any and all claims against the Foundation. I understand that I may revoke this consent at any time with a written request.

Name of Responsible Party: _____

Signature: _____ Date: _____

BAFI: _____ Date: _____

Revised: 01/23/2017

Brevard Alzheimer's Foundation, Inc.
Do Not Resuscitate Order

ORGANIZATIONAL POLICY AND PROCEDURE

It is the policy of the Brevard Alzheimer's Foundation, Inc. (BAFI) not to accept "Do Not Resuscitate Orders" for participants attending any of the three Clubs.

If, in the opinion of the trained BAFI staff, a medical emergency occurs involving a participant while in attendance at Joe's Club, the staff will perform the following functions:

1. 911 Emergency will be called immediately; (if a participant is a Hospice patient and a Hospice nurse is on the premises, Hospice will be directed to handle the situation).
2. Trained BAFI staff will administer basic CPR and first Aid, if necessary, and everything possible will be done to comfort the participant;
3. The primary caregiver of record will be contacted; and
4. Documentation of the incident will be included in the participant chart

The foregoing policy and procedure will be followed notwithstanding any directions otherwise.

I have read and fully understand the above policy. I also understand that this form will become a part of my loved one's participant chart.

Responsible Party's Name (Please Print)	Participant's Name (Please Print)
Signature	Date

Revised 1/24/2017

THE ADULT DAY CARE PROGRAM
SUMMARY OF POLICY AND PROCEDURES
FOR CLUB MEMBER CARE

Each Club member is:

1. Allowed to retain the services of his/her personal physician.
2. Assured of services described in the protocol.
3. Offered the opportunity to participate in the planning of his/her care.
4. Assured of remaining free from mental and physical abuse, and free from chemical and physical restraints.
5. Assured of privacy in the terms of his/her medical records.
6. Treated with consideration, respect, and full recognition of his/her dignity, individuality, and the right to privacy.
7. Permitted to participate in the Club activities and to meet with and participate in activities of social, religious, and community groups at his/her discretion.
8. Assured of the opportunity to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, is imposed on any Club member. Joe's Club encourages and assists in the exercise of these rights.
9. Not the object of discrimination with respect to participation in activities which include, but are not limited to, recreation, meals, leisure, other social activities because of age, race, religious, sex, or nationality as defined in *Title VI of the Civil Rights Act of 1964,* or *Section 504 of the Rehabilitation Act.*
10. Not deprived of any constitutional civil, and/or legal right solely by reason of admission.
11. Allowed (for the Club member's protection) to discharge him/herself from the Club program upon presentation of a request, in writing; or if the Club member is an adjudicated mentally incompetent, upon the written request of the guardian, next of kin, or "Responsible Party" named at the time of intake; in no case will a Club member be able to discharge him/herself until the Club staff notifies the appropriate person.
12. Allowed to be dismissed or terminated only for a) medical reasons, b) his/her own welfare or that of others, or c) non-payment of fees for services (only after reasonable alternatives have failed, have been given written notification of discharge and are given fifteen (15) days to arrange for alternative services, except in cases of emergency as determined by the governing authority of the Club.
13. To be given reasonable advance notice of any discontinuance of service, except in the case of emergency as determined by the Center Manager or Licensed Nursing Staff or Social Worker and the Executive Director of the Brevard Alzheimer's Foundation, Inc.
14. Informed of his/her rights to report abusive, neglectful, or exploitative practices. The number is: ***1-800-96ABUSE*.**

I, the undersigned, have read and fully understand the above policy.

Responsible Party's name (Please Print)	**Client's Name (Please Print)**
Signature	**Date**

GRIEVANCE PROCEDURES

For purposes of this policy, a grievance is defined as any dispute between the client (to include both Club Member and Caregiver) and The Club as part of the Brevard Alzheimer's Foundation, Inc. (hereafter referred to as BAFI) involving the interpretation of BAFI's policies and procedures. Any client that is not satisfied with the service provided, feels affirmed, or is facing termination or reduction of services shall discuss the issue with the Center Manager. Any client not satisfied with the results of the discussion may file a written grievance as contained in this policy.

Purpose of Procedure

The purpose of this grievance procedure is to provide each client with the opportunity to review and discuss disputes or differences. The filing of a grievance by a client shall in no way affect the client's status with BAFI.

Action Step One

The aggrieved client must present a grievance in writing to BAFI within ten (10) calendar days after the date of the occurrence. The Center Manager will investigate, report to the Executive Director and the grievance will be addressed in writing to the aggrieved client within ten (10) calendar days after receipt of the grievance. Services may not be reduced or terminated during the ten (10) calendar day period.

Action Step Two

If the client is not satisfied with the written response of the Center Manager/Executive Director, the client may appeal the finding in writing within seven (7) calendar days to the Chairman of the Executive Committee of BAFI. The Chairman will respond in writing to the aggrieved client within seven (7) calendar days. The response will include: a time and place for the review; assignment of one or more unbiased persons appointed to review the case. The client will be given the opportunity to present the argument(s), evidence and witnesses without interference during the review. If necessary, a contact person for any accommodations necessary under the Americans with Disabilities Act will be provided. Once the Chairman of the Executive Committee hears the grievance and makes a decision, the decision is the final step in the BAFI Grievance Procedure.

Action Step Three

Any eligible client who had first followed the hearing complaint procedures established by BAFI, and who still feels the issue is unresolved, may present a complaint to the Area Agency on Aging (AAA) and follow their respective grievance procedures. The local AAA is the Senior Resource Alliance, 988 Woodcock Road, Suite 200, Orlando, FL, 32803.

_____ _____

Signature Date

_____ _____

Responsible Party's Name (Please Print) Participant's Name (Please Print)

Revised: 01/23/2017

Persons Authorized to Pick up Club Member from _____ Center

Club Member's Name: _____

Primary Caregiver's Name: _____

Please list all family members, friends, caretakers, etc. who are authorized to pick up your loved one from The Club. Only people on this list will be allowed to pick up the above names Club Member. Any person who is not on the list who attempts to pick up the Club Member will be denied and the primary caregiver listed in the Club Member's chart will be contacted.

If it is necessary for someone other than those listed below to pick up your loved one you must make prior arrangements by notifying the staff at The Club at 321-253-4430. If possible, at least one (1) day notice prior to pick up is requested.

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Acknowledgement of Transportation Policy

The following policies are designed to ensure our passengers receive the best service in the safest possible manner, and include the responsibility of both the driver and Caregiver.

Loading/Unloading:

Caregivers are responsible for:

1) Pick Up: Bringing the passenger from the residence to the van and assisting in the loading process.
2) Drop Off: Assisting in the unloading process and taking the passenger to the residence.

- Drivers are prohibited from leaving passengers unattended in the van.
- It is BAFI's policy that if a passenger uses a cane, walker or wheelchair, or if there are any other concerns for the safety of the passenger on the stairs of the van, a wheelchair lift SHALL be used.

  1) For the safety of all concerned, a van driver operating a wheelchair lift shall remain on the ground while the lift is being raised or lowered and must stay at the van at all times. CAREGIVER / CNAs are responsible to bring the client onto and off the van at home/facility. If the client is too unsteady or requires assistance while riding the lift, the caregiver/CNA will need to assist. If too unsteady, or if the caregiver is unable to assist, a wheelchair shall be used to make the transition onto and off of the van. The driver will load and unload wheelchairs onto or off of the lift platform and operate the lift.
- Passengers shall correctly wear safety belts at all times. All passengers using wheelchairs shall be secured using a four-point tie-down system with the appropriated lap belts and shoulder straps.

Scheduling:

- While we strive to maintain an accurate schedule, the arrival time at a residence varies daily depending on attendance at BAFI, and other outside influences (traffic, weather, etc).
- BAFI asks that passengers and caregivers be ready 10 minutes before and beyond the scheduled pick-up time. Every attempt shall be made to contact the passenger. Passengers who do not make themselves available within that window will be considered a no-show.
  1) In the event of a No Show, the caregiver will be charged the equivalent of a one-way trip to BAFI.
- When a driver becomes aware that they will be late for a scheduled pick-up by 10 minutes or more, the driver will notify the passenger or the designated caregiver directly, or contact the BAFI office.

Name of Caregiver/Responsible Party: _____

Signature:_____ Date: _____

BAFI: _____ Date: _____

Drafted: 6/30/2017

The Brevard County Special Needs Program is a space-limited program for which people with specific health and medical conditions can register, providing sheltering and transportation with the resources available in Brevard County.

The Special Needs Registry is a confidential listing of those people who meet program criteria, and is updated on an annual basis. Patients with colostomy assistance needs, nebulizers, oxygen, feeding tubes, or Alzheimer's disease are examples of medical criteria that are eligible for the registry.

While the Office of Emergency Management recommends sheltering with friends or family members, public shelters are available for those who do not have other alternatives.

Individuals who elect to use a Special Needs or other public shelter should bring with them items such as cots, bedding, medicine, medical supplies, and food supplies, preparing to be self-sufficient for 72 hours. The community pages of the telephone book provide lists of recommended items to take to a shelter. Special Needs registrants should also be accompanied by at least one caregiver.

Most shelters are located in public schools, and offer neither privacy nor luxuries. Occupants' comfort will be determined by their preparedness.

The Special Needs registration request form can be found on-line at: http://web.brevardcounty.us/specialneeds/registration.aspx or for more information call (321) 637-6670.

Service Form

I have been offered the opportunity to apply for evacuation assistance from the Brevard County Special Needs Program.

☐ **I Do Not Want Assistance**
for transportation or shelter placement at this time.

If I desire assistance in the future, I understand it is my responsibility to contact the Office of Emergency Management: (321) 637-6670

PLEASE PRINT:

Last Name:_____First Name: _____

Client Address: _____

Client Telephone: _____

CLIENT SIGNATURE_____ DATE: _____
Signature of Registrant or Guardian (Required)

AGENCY: Brevard Alzheimer's Foundation, Inc.

Please complete this form and return to: Brevard County Emergency Management
1746 Cedar Street
Rockledge FL 32955
(321) 637- 4088
(321) 633-1738 (Fax)

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Part 1. All Household Members

Name of Enrolled Adult(s): (List name under Names of Adult Participants)

Names of Adult Participants (First, Middle Initial, Last)	CHECK IF NO INCOME
	☐
	☐
	☐

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], [State SSI] or [Medicaid], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

TYPE OF BENEFIT (CHECK ONE): ☐ SNAP ☐ FDPIR ☐ SSI ☐ Medicaid

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** the participant(s), spouse and dependent children of participant(s))	**B. Gross income and how often it was received**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 4. Signature and Last Four Digits of Social Security Number

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-__ __ __ __ ☐ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ Asian ☐ White ☐ Black or African American	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Adult Care)

Don't fill out this part. This is for official use only.

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

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Paid___ Denied___

Reason: _____

Determining Official's Signature: _____ Date: _____

Household size	Yearly- Free	Yearly- Reduced-Price
1	$ 0 – $15,678	$ 15,679- $22,311
2	$ 0 – $21,112	$ 21,113- $30,044
3	$ 0 – $26,546	$ 26,547- $37,777
4	$ 0 – $31,980	$ 31,981- $45,510
5	$ 0 – $37,414	$ 37,415- $53,243
6	$ 0 – $42,848	$ 42,849 - $60,976
7	$ 0 – $48,282	$ 48,283- $68,709
8	$ 0 – $53,716	$ 53,717 - $76,442
Each additional person:	+ 5,434	+ 7,733

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: "The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (in Spanish).

USDA is an equal opportunity provider and employer."

The Brevard Alzheimer's Foundation has partnered with BioClinica to provide you and your loved ones with access to clinical research and drug trials. Please provide information below if you would like a representative from BioClinica Research to contact you with more information.

☐ Yes, I would like more information

☐ No, I am not interested at this time

_____
Age

I am interested in:
❑ Research Studes
❑ Memory Screening

_____ _____
Printed Name of Club Member or Legal Guardian Date

_____ _____
Signature of Club Member or Legal Guardian Phone Number