

**2024
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Executive Director

Elizabeth Rummage



601 W. Center Street
Lexington, NC 27292

Phone: 336-249-2155
FAX: 336-249-2374

Email:
info@

lifecenterdavidson.com

www.

lifecenterdavidson.com

TO THE APPLICANT AND FAMILY MEMBERS:

This form allows for the release of medical information from the physician of the applicant to The Life Center of Davidson County, Inc. and should be given to the applicant's physician upon completion. The information provided to us on this form is required by State standards. The information also helps us to determine how we can best meet the medical needs of the applicant. The information is used solely by The Life Center of Davidson County, Inc. to determine whether or not an adult day program is the appropriate health care option for the applicant.

The physician may return the form directly to you or send it to The Life Center via fax, our number is: 336-249-2374. The form must be completed in its entirety and received by The Life Center before the applicant's first day. It will be due annually thereafter. In order for the physician to release the information to The Life Center of Davidson County, Inc., please complete the following portion prior to giving this form to the physician.

I, _____, allow the release of medical information
(Applicant or Responsible Family Member)

about _____
(Applicant)

to The Life Center of Davidson County, Inc. for the purpose of determining the feasibility of the applicant's participation in an adult day program by his/her physician,

Dr. _____

Practice: _____

Date: _____

Reviewed November 21, 2022
Elizabeth G. Rummage
Executive Director



Medical Information Form

The Life Center of Davidson County

Name of Participant: _____

Birth Date: _____ Most Recent Date Seen By Physician: _____

Medical Diagnosis: Please Check:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> COPD/Respiratory problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> BPH/PSA | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> CAD/Angina |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Cancer-Type: _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Gastric Ulcers | <input type="checkbox"/> Chronic Renal Failure |
| <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> HTN | <input type="checkbox"/> Diabetes: Type I or Type II |
| <input type="checkbox"/> MI/Cardiac | <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Epilepsy/Seizure Disorder |
| <input type="checkbox"/> Defib/Pacer | <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Atrial Fib. | <input type="checkbox"/> Cardiac Arrhythmias |
| <input type="checkbox"/> Effects of Stroke - (Specify): _____ | <input type="checkbox"/> Urinary Problems: - (Specify): _____ | <input type="checkbox"/> Cardiomyopathy |
| <input type="checkbox"/> Visual Problems - (Specify): _____ | <input type="checkbox"/> Skin Disorder - (Specify): _____ | |
| <input type="checkbox"/> Hearing Problems - (Specify): _____ | <input type="checkbox"/> Psychiatric Issues - (Specify): _____ | |

ANY OTHER ILLNESSES NOT LISTED ABOVE: _____

- ☐ YES ☐ NO Does the participant have any COMMUNICABLE disease?
If so, specify: _____
- ☐ YES ☐ NO Does the participant require constant supervision to make sure
he/she does NOT do harm to self, others or to property?
- ☐ YES ☐ NO Will this person wander if not closely attended to?
- ☐ YES ☐ NO Do you recommend any restrictions for medical reasons on physical
activities such as walking, exercise, etc.?
If so, specify: _____
- ☐ YES ☐ NO Does the participant have any ALLERGIES to medications, foods or Latex?
If so, specify reactions: _____
- ☐ YES ☐ NO Does the participant have difficulty understanding conversations
or communicating needs?
- ☐ YES ☐ NO Is the participant a HIGH RISK FOR FALLS?
- ☐ YES ☐ NO Is the participant at HIGH RISK OF CHOKING?
- ☐ YES ☐ NO Does the participant have any special dietary needs?
If so, specify: _____

Consistency: Reg. ☐ Cut up ☐ Chopped ☐ Ground ☐ Thicket ☐

The Life Center Provides an 1800 calorie ADA diet.

Medications	Strength	Time Given	Purpose

PRN STANDING ORDERS FOR MEDICATION:

Please Check if the following may be given at The Life Center:

- ☐ YES ☐ NO Tylenol (Acetaminophen) 500 mg-2 tabs/caplets PO or elixir q 6 hrs PRN for mild pain or temperature greater than 100 degrees.
☐ YES ☐ NO Robitussin 15cc PO q 4 hrs PRN for simple cough-Not to exceed 4 does in 24 hours.
☐ YES ☐ NO Mylanta/Maalox 30cc PO q 4 hrs PRN for indigestion-Not to exceed 4 does in 24 hours.
☐ YES ☐ NO Triple Antibiotic Ointment to minor abrasions and wounds PRN. May use Steri-Strips if needed.
☐ YES ☐ NO Cold Compresses for simple trauma & Warm Compresses for pain or inflammation.
☐ YES ☐ NO Menthol Cough Drops q 2 hrs PRN for cough or sore throat.
☐ YES ☐ NO Milk of Magnesium 30cc q day PRN for constipation.

LIST ANY OTHER OTC MEDICATIONS THAT ARE TO BE GIVEN:

Participants typical Blood Pressure: _____ Blood Sugar: _____

Height: _____ Weight: _____

The Life Center monitors the participants' Blood Pressure and Weight Monthly.

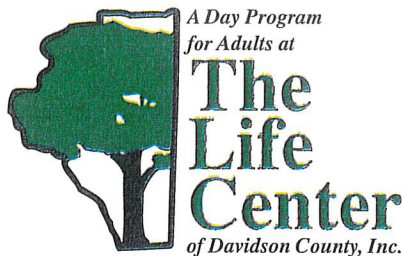
Printed Name of PCP/PA/NP: _____ Date: _____

Signature of PCP/PA/NP: _____ Date: _____

Name of Practice: _____

Address: _____

Phone: _____ Fax: _____



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To the Applicant, Family Member or Responsible Person:

Attached is an application for participation in the adult day care/adult day health program of The Life Center of Davidson County, Inc. The information on this application is confidential and will be used to enable our staff and Quality Assurance committee members to assess whether we can provide the level of care requested. Financial information will be used only to determine eligibility for fee assistance programs.

Upon receipt of the application and medical form (which is to be completed by the applicant's physician), the family should call to schedule an interview. The purpose of this visit is to further assess the ability of The Life Center to meet the needs of the applicant and their family and to acquaint the applicant with our center and staff.

The application must be completed in its entirety to be considered. It will be processed as quickly as possible; however, a ten-day working period should be allowed between the receipt of the application and medical form by The Life Center and the participant's first day of participation.

Please do not hesitate to call if you have any questions. I look forward to meeting you and telling you more about our services.

Sincerely,

Elizabeth G. Rummage
Executive Director

Enclosure



PARTICIPANT AND FAMILY INFORMATION
The Life Center of Davidson County, Inc.

Applicant's Full Name: _____
First Middle Maiden Last

Applicant's Mailing Address: _____
City & Zip code: _____

Applicant's Home Phone: (____) _____ - _____

Applicant's Social Security Number _____ - _____ - _____ **REQUIRED**

Applicant's Date of Birth ____/____/____ Email Address _____

Medicare Number _____ Medicaid Number _____

Does the recipient receive or has applied for Supplemental Security Income? (SSI) ____Y ____N

Is the participant receiving Adult Protective Services? ____Y ____N

Does the household receive Food Stamps? ____Y ____N

Name of person receiving Food Stamps: _____

To the family:

- What interested you in the services provided by The Life Center?
- How did you learn about The Life Center?
- Have you been involved with another adult day care/adult day health program?

About the Applicant (This information helps us to get to know the applicant.)

- Is the applicant ____Single ____Married ____Divorced/Separated ____Widowed
- If they do not live alone, with whom do they live?
- Did the applicant work and if so where?
- Where did they attend school?
- What was the highest grade level they completed?
- Are they a part of a faith based community?
- What hobbies does the applicant enjoy?
- What activities does the applicant participate in on a typical day?
- If currently receiving the services of a home health agency, which agency?
- Were they in the armed services? If so, when and in what branch did they serve?

Family Information

- Who is responsible for the applicant (overseeing care, paying bills, etc.)?

Name: _____ Phone Number: (____) _____ - _____

Mailing Address: _____

- Is this person a Power of Attorney for the applicant?

- If the applicant has children, please list their names, mailing addresses, and e-mail addresses

- If the applicant has grandchildren, please list their names.

About the applicant's doctors:

Name of Primary Care Physician: _____ Phone Number: (____) _____ - _____

Mailing Address: _____

- If you have more than one physician, please provide a list of all physicians.

Name of Dentist: _____ Phone Number: (____) _____ - _____

Mailing Address: _____

Emergency contact phone numbers -REQUIRED

There are times we might need to get in touch with a family member or friend including, in the event of an emergency, to obtain necessary information, or if the participant is late, absent, or remains at The Life Center after closing. If a phone number changes, please provide new information.

Name: _____ Relationship: _____

Mailing Address: _____

Daytime Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Mailing Address: _____

Daytime Phone: _____ Cell Phone: _____

About transportation

- Do you have transportation to and from The Life Center _____YES _____NO

If yes, who will provide the transportation _____

Approximately what time will the applicant arrive? _____am What time will they leave? _____pm

If no, do you need for transportation to be arranged, if available? _____YES _____NO

Additional information about the applicant:

Please check below if any of the following applies to the participant. Please feel free to add additional comments when needed.

_____ The applicant is occasionally confused or disoriented (less than once a week).

_____ The applicant is frequently confused or disoriented (daily).

_____ The applicant has wandered away from home before. How many times? _____

_____ The applicant cannot feed him/herself.

_____ The applicant is on a special diet.

What type? No Added Salt _____, Low Salt _____, Diabetic _____, Ground Foods _____, Other _____

_____ The applicant has problems with choking. How frequently? _____

_____ The applicant has frequent loss of bowel or bladder control.

_____ The applicant wears a "Depends" type garment.

_____ The applicant needs assistance to go to the restroom.

_____ The applicant has had a mastectomy. When _____ Left Side _____ Right Side _____ Both _____

_____ The applicant wears glasses.

_____ The applicant wears contact lenses.

_____ The applicant has a pacemaker.

_____ The applicant has difficulty understanding normal conversations and following instructions.

_____ The applicant is unable to read and write.

_____ The applicant needs large print to read.

_____ The applicant has a history of seizures.

_____ The applicant has allergies. Please list.

_____ The applicant falls frequently. How frequently? _____

_____ The applicant uses a _____ walker, _____ cane, _____ wheelchair.

_____ The applicant needs assistance with ambulation.

The applicant uses tobacco products. _____ Cigarettes _____ Chewing tobacco or snuff/dip

_____ The applicant has the following special care needs:

Is there any additional information which might help us to provide care to the applicant?

Medications:

Please list all of the applicant's medications (prescription and over the counter) **-whether they will be taking them at home or The Life Center.** Any changes should be reported in writing immediately as this information is provided to emergency personnel when needed. **This information is REQUIRED.**

Name of Medication	Dosage	When Taken	Why Prescribed

If additional medications are taken, please attach list.

- Which most accurately describes the applicant?
____ Is able to take own medications without assistance.
____ Needs reminding to take medications.
____ Cannot take medications without assistance.
 - Will the applicant be taking medications while at The Life Center? ____ YES ____ NO
 - Does the applicant have any drug allergies? ____ YES ____ NO
- If yes, please list all drug allergies: _____

NOTE: If the recipient and/or caregiver will pay for the cost of services, NO Financial Information is required.

The following information will be used by The Life Center to document the recipient's eligibility for federal funding, and to allow The Life Center to apply for federal funding reimbursement. All information will remain confidential.

Please circle the total income of the applicant, and their spouse, if applicable. Income includes social security, pensions, dividends, retirement benefits, interest income from savings, bonds, and stocks, income from estates, trusts, royalties, and rental property, wages from employment, unemployment benefits, workers compensation, alimony, etc.

Monthly Income of:

Individual	Couple
\$903-\$1,128	\$1,214-1,518
\$1,129-1,354	\$1,519-1,821
\$1,355-1,579	\$1,822-2,125
\$1,580-1,805	\$1,850-2,428
\$1,806-2,031	\$2,429-2,732
\$2,032-2,257	\$2,733-3,035
\$2,258-2,482	\$3,036-3,339
\$2,483-2,708	\$3,340-3,642
\$2,709-3,161	\$3,643-4,249
\$3,162-Above	\$4,250-Above

- **Expenses**

Please list monthly expenses incurred by the applicant:

Rent/Mortgage: _____

Utilities: _____

Prescription Drug Costs: _____

Home Modifications: _____

Special Needs Costs: _____

Caregiving Costs: _____

- **In the event of an emergency:**

Please check if the applicant has any of the following documents:

_____ A Living Will

_____ Do Not Resuscitate Orders

_____ Advanced Directives

_____ Health Care Power of Attorney

Does the applicant have a hospital preference? If yes, please list the hospital.

Does the applicant have hospital insurance in addition to Medicare/Medicaid? _____ YES _____ NO

- **The following are things we do in our day to day lives. Please check if the applicant is capable of accomplishing the following tasks.**

_____ eat a meal without assistance

_____ dress without assistance

_____ take a bath without assistance

_____ go to the bathroom without assistance

_____ get up from a chair without assistance

_____ communicate wants/wishes/thoughts

_____ walk without staff assistance

_____ know when she/he has to go to the bathroom and is able to act on that urge

_____ prepare a meal without assistance

_____ take medication properly without assistance

_____ clean the house without assistance

_____ manage money properly without assistance

_____ make a phone call without assistance

_____ do laundry without assistance

_____ read a book

_____ go grocery shopping

RELEASE OF INFORMATION

In the event of a medical emergency, I allow release of information necessary for The Life Center of Davidson County, Inc. to determine the ability to meet the medical needs of the applicant.

I also allow release of information necessary for The Life Center of Davidson County, Inc. to document my eligibility for federally funded programs.

I understand this information will not be used for any purpose other than to document my eligibility and feasibility to participate in the adult day program.

RELEASE FOR MEDICAL TREATMENT

- I AUTHORIZE THE STAFF OF The Life Center of Davidson County to assist the applicant's taking of his/her medications as prescribed by his/her physician.
- I give my permission for emergency treatment as deemed necessary by The Life Center staff or emergency personnel.
- I give permission for the applicant to be treated in the emergency room of the nearest hospital in the event of an emergency.
- I give permission for emergency treatment, as deemed by a physician, either in his/her office or emergency room.

CONSENT TO PHOTOGRAPH

I give permission to The Life Center of Davidson County for this named person

to be photographed for the purpose of promoting the services of The Life Center in newspaper articles, slide or video presentations, television stories, and/or social media. I also allow The Life Center to retain film, negatives, or prints from such photographs.

STATEMENT OF UNDERSTANDING

I have received a copy of the Family/Participant Handbook (Policies and Procedures of The Life Center) and understand the responsibilities of the family and The Life Center and agree to abide by them.

Applicant's Signature _____

Date _____

Signature of Responsible Person _____

Date _____

Signature of Life Center Staff _____

Date _____



*A Day Program
for Adults at*

The Life Center

of Davidson County, Inc.

Inquiry Packet

The Life Center of Davidson County Information about Services

Mission

The mission of The Life Center of Davidson County, Inc. is to provide high quality day time care to older and impaired adults; to help improve the quality of life for both the participant and their caregivers by offering a safe supportive environment, support, relief, respite, and counseling.

The Life Center serves adults 18 years of age and older residing in Davidson County and surrounding counties. The services are geared toward individuals 60 years of age and older; however, special consideration is given to those under the age of 60 whose needs may be met in an adult day health program setting.

Goals

The Life Center's goals are:

- To provide a safe and secure environment for caregivers to leave their family member during the day time.
- To provide activities to stimulate participants mentally, physically, and socially.
- To provide a supportive environment to increase the participant's feelings of self-worth and dignity.
- To emphasize health rather than illness.
- To provide health services to enhance care provided by the participant's family and physician.
- To provide a loving, nurturing environment to enhance the quality of the participants' lives.
- To encourage companionship and friendship.
- To provide a time of respite and renewal for the caregiver.

Family Benefits

The intent of The Life Center's services is to enhance the care given by a family member for a loved one and to help the family continue to care for them in their home. The Life Center can offer family support and freedom to pursue employment opportunities and outside interests without worrying about their loved one. Our services are less costly than in-home care and serve to avoid premature long-term care placement.

Questions

Families are encouraged to visit and be involved in the activities of The Life Center as often as possible. Making a decision about care for a loved one is often a difficult decision at best. The staff of The Life Center is available to answer your questions.

Please contact us with any questions you may have:

- Come by The Life Center anytime during our business hours of 8:00am-4:30pm. We are located at the corner of West Center and Martin Streets in Lexington.
- Write to us at 601 West Center Street, Lexington, NC 27292.
- Call us at 336-249-2155.
- Email us at info@lifecenterdavidson.com.
- Visit us on the web at www.lifecenterdavidson.com.

We will put you in touch with the person who can best answer your questions.

Testimonies

Each year The Life Center surveys our families to ask them how we are doing. We want to know, Are we meeting their needs? What should we change? What services should we add? Here are some of the comments from our surveys:

- "It's a wonderful place to take your parent to get good quality care."
- The Life Center "provides kind, loving care and good educational and fun activities."
- The Life Center is "a caring group of dedicated personnel. Their goal is to provide the best care possible for their participants."
- "The Life Center provides a vital service for families and allows elderly people to remain at home. It is a service we all may need one day."
- "The Life Center provides a very clean, safe, and inviting environment with trained and qualified caregivers."
- "If it weren't for The Life Center, my Mom would be in a rest home. I could not afford to quit work."
- "Thank you for your kindness, caring, patience, humor, smiles, understanding, teamwork, and friendship."
- "The freedom and mental rest given to the spouse while the person is at The Life Center is great."
- "This is a great place for senior citizens to go and spend a day with friendly folks and not be alone. I am able to work and not have to worry about my Mother."
- You "took such special care of Mom. She loved you all."
- People should "visit and see for themselves" what The Life Center is all about.
- Your center "is truly a Life Center."

Leadership and Staff

The Life Center of Davidson County is a private, non-profit agency governed by a volunteer Board of Directors. The Life Center's professional staff include an Executive Director, Assistant Director, Program Coordinator, Health Care Coordinator, Chef, and Health Care Assistants. Staff has been trained in the CARES® Online Dementia Training Program and certified in the Alzheimer's Association's™ program.

Staff members are trained to work with older and impaired adults and are certified in both CPR and First Aid. Our staff to participant ratio is *no greater than 6 participants to each staff member*. Volunteers for activities such as crafts, sing-a-longs, receptionist, and informational programs are drawn from community resources and individuals.

Transportation

Family members are encouraged to provide transportation for the participant when feasible. For those families who are unable to provide transportation, The Life Center will contact the Davidson County Transportation System to determine if a space is available to transport participants to and/or from their homes.

Costs

The Life Center's fees are based on the cost of providing care. The cost depends upon the number of days of care needed, the level of care required, and the amount the family can afford to pay. Through government programs, United Way contributions, and donations from corporations, churches, and individuals in our community, many participants are eligible for scholarships to make the program more affordable.

We will discuss with you all cost information and the availability of existing grants and/or scholarships during your visit to the center.

How Do I Enroll My Loved One?

Attached is an information form and a medical form. After these forms are completed by the family and physician, the person responsible for the care of the participant should call to arrange an appointment time with the Program Coordinator and schedule a visit to The Life Center to complete the enrollment process.

The enrollment process is designed to give the applicant, his or her family, and The Life Center the opportunity to determine if The Life Center is the most appropriate service for the applicant. It is also designed to acquaint the applicant with The Life Center facility. Therefore, **the applicant should accompany the family** to The Life Center for this visit. The family should allow about 90 minutes. A \$25.00 enrollment fee will be collected before the enrollment. The enrollment fee will be waived for care recipients living below poverty level.

Activities

Therapeutic activities are a core component of the services provided by The Life Center and are available to each participant. We offer a varied program of activities designed to enhance the adult's feelings of self-worth and usefulness, stimulate creativity, provide safety and peer association.

Activities are planned to meet the interests, needs, and abilities of the participants with an emphasis placed on utilizing each participant's strengths. Time is also scheduled for rest and relaxation. Some of our activities include: guest speakers, exercise, health and nutrition education, cultural enrichment, intergenerational programs, crafts, music therapy, gardening, devotions, trivia, trips down memory lane, games, and more. Safe 'wandering' is permitted within the building and onto the screened porch.

Activities are planned and paced for the needs of the adult and are aimed at maintaining the highest possible level of functioning. Activities are never forced upon a participant and personal attention is provided when needed.

Is The Life Center Right for my Loved One?

The Life Center will strive to serve all participants. Decisions regarding acceptance into the program are determined on an individual basis.

The following describes individuals who are happiest in an adult day health setting.

- Benefits from a therapeutic activity program.
- Benefits from the companionship of others.
- Transfers from a wheelchair to a chair with minimal assistance.
- Adapts to the group setting both physically and mentally.
- Feeds him/herself independently or with cueing.
- Benefits from bowel/bladder retraining.
- Is not disruptive, is not verbally or physically harmful to others.

If you have questions about a specific health care need, or our ability to meet that need, please contact us.

Health Care Services

Health care staff assist the participant with taking medications, following special diets, walking and moving about the center, monitoring their health through regular blood sugar and blood pressure checks, maintaining mobility through individualized range of motion exercises, bowel and bladder retraining, and more.

Additional fee based health services include: daily/weekly blood sugar checks, blood draws, bathing, hair care, limited transportation, and more. See the private pay fee schedule attached.

Special Diets

A light breakfast, nutritious lunch, and an afternoon snack are part of the services provided. Participants with special dietary needs, as prescribed by a physician, will receive foods to meet their special diets (vegetarian, cut up, or ground.)

Hours

The Life Center is open Monday through Friday except on holidays and staff workdays. Our operating day is **7:30 a.m. to 5:00 p.m.**

A Typical Daily Schedule

Morning:

7:30-8:25	Weather and News-Social Time
8:25	Thought for the Day and Pledge
8:30	Light Breakfast
9:00	Current Events and What's New
9:30	Morning Exercise
10:00	Morning Activity (Trivia, Music, Physical Challenge, etc.)
11:00	Price is Right TV Time or Small Group Activities

Afternoon:

12:00	Lunch
12:30	Quiet Time/Small Group Activities
1:30	Afternoon Activity (Exercise, Crafts, Bingo, etc.)
2:00	Afternoon Snack
2:30-4:45	Small Group Activities
5:00	Center Closes



United Way
of Davidson County