A Day Program for Adults at

The Life Center

of Davidson County, Inc.

SCAN ME

United Way of Davidson County PARTNER AGENCY

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, Inc.

Participant Name: _____

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

Medical Diagnosis – Please Check:

☐ Anemia	☐ Anxiety Disorder	☐ COPD/Respiratory Problems
☐ Asthma	☐ BPH/PSA	☐ Arthritis
☐ CHF	☐ Chronic Bronchitis	☐ CAD/Angina
☐ Dementia	☐ Alzheimer's	☐ Cancer – Type: _____
☐ Emphysema	☐ Gastric Ulcers	☐ Chronic Renal Failure
☐ GERD/Reflux	☐ HTN	☐ Diabetes - ☐ Type 1 or ☐ Type 2
☐ MI/Cardiac	☐ Developmentally Disabled	☐ Epilepsy/Seizure Disorder
☐ Defib/Pacer	☐ Depression	☐ Parkinson's
☐ Pneumonia	☐ Atrial Fib.	☐ Cardiac Arrhythmias
☐ Cardiomyopathy	☐ Effects of a Stroke – Specify: _____	

☐ Urinary Problems – Specify: _____

☐ Visual Problems – Specify: _____

☐ Psychiatric Issues – Specify: _____

☐ Skin Disorder – Specify: _____

☐ Hearing Problems – 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 they do not harm themselves, others, or property?

☐ Yes ☐ No Will this person wander if not closely attended to?

☐ Yes ☐ No Do you recommend any restrictions from medical reasons on physical activities such as walking, exercise etc.? If so, specify: _____

☐ Yes ☐ No Does this participant have any ALLERGIES to medications, food, or Latex? If so, specify the 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: ☐ Regular ☐ Cut-up ☐ Chopped ☐ Ground ☐ Thickened

Please list medications or attach a printed list from your Primary Care Physician or Pharmacist

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 doses in 24 hours.

☐Yes ☐No Mylanta/Maalox 30 cc PO q 4 hrs PRN for indigestion – Not to exceed 4 doses 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:

Participant's Typical Blood Pressure: _____ Typical Blood Sugar: _____

Height: _____ Weight: _____

The Life Center monitors the participant's Blood Pressure and Weight monthly.

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

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

Name of Practice: _____

Adress: _____

Phone: _____ Fax: _____

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of Davidson County, Inc.

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

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

PARTICIPANT INFORMATION

Full Name: _____
First Middle Maiden Last

Mailing Address: _____

City & Zip Code: _____

Home Phone: _____

Social Security Number (**REQUIRED)**: _____

Date of Birth: _____

Email Address: _____

Medicare Number: _____ Medicaid Number: _____

Does the participant receive or has applies for Supplemental Security Income (SSI)? ☐Yes ☐No
Is the participant receiving Adult Protective Services? ☐Yes ☐No
Does the household receive Food Stamps? ☐Yes ☐No
If yes, name of person receiving Food Stamps: _____

To the family:

- What interested you in 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? ☐ Yes ☐ No
  - If yes, where? _____

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 they completed?
- Are they part of a faith-based community?
- What hobbies does the applicant enjoy?
- What activities does the applicant participate in on a typical day.

About the Applicant Cont.

- 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: _____

Email Address: _____

Is this person Power of Attorney for the applicant? ☐Yes ☐No

If the applicant has children, please list their names, mailing address, email addresses, and phone numbers.

CHILD 1	Name:		Phone Number:	
	Mailing Address:			
	Email Address:			

CHILD 2	Name:		Phone Number:	
	Mailing Address:			
	Email Address:			

CHILD 3	Name:		Phone Number:	
	Mailing Address:			
	Email Address:			

If the applicant has grandchildren, please list their names:

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

About the Applicant's Doctor:

Name of Primary Care Physician: _____

Mailing Address: _____

Phone Number: _____

If you have more than one physician, please attach a list of physicians to this application.

Name of Dentist: _____

Mailing Address: _____

Phone Number: _____

Emergency Contact Phone Numbers – REQUIRED SECTION

There are times we might need to get in touch with a family member or friend. 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

Contact 1				
	Name:		Phone Number:	
	Mailing Address:			
	Email Address:			

Contact 2				
	Name:		Phone Number:	
	Mailing Address:			
	Email Address:			

About Transportation

Do you have transportation from your home to and from The Life Center? ☐ Yes ☐ No

If yes, who will provide transportation? _____

Approximately, what time will the applicant arrive? _____ A.M. What time will they leave? _____ P.M.

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 apply. 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 themself.

☐ The applicant is on a special diet. If so, 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 has had a mastectomy. If so, when? _____ ☐Left Side, ☐Right Side, or ☐Both

☐ The applicant wears glasses.

☐ The applicant wears contact lenses.

☐ The applicant wears 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.

Medications – Please list all of the applicant's medications (prescription and over the counter) – **whether they will be taking them at home or at 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	Time Taken	Why Prescribed

If additional medications are taken, please attach a list to this application.

Which most accurately describes the applicant?
☐ Is able to take their own medications without assistance.
☐ Needs reminders to take their medication.
☐ Cannot take their 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: _____

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, ad 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, stocks, income from estates, trusts, royalties, and rental property, wages from employment, unemployment benefits, worker's compensation, alimony, etc.

Monthly Income of:

Individual	Couple
$1,255	$1,703
$1,256 – $1,568	$1,704 – $2,128
$1,569 – $1,882	$2,129 – $2,554
$1,883 – $2,195	$2,555 – $2,980
$2,196 – $2,509	$2,981 – $3,406
$2,510 – $2,823	$3,407 – $3,832
$2,824 – $3,137	$3,833 – $4,257
$3,138 – $3,450	$4,258 – $4,683
$3,451 – $3,764	$4,684 – $5,109
$3,765 – $4,392	$5,110 – $5,961
$4,393 – above	$5,962 – above

Monthly Expenses – Please list estimated 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 is the applicant has any of the following documents:

- ☐ A Living Will
- ☐ Do Not Resuscitate Orders (DNR)
- ☐ Advance Directives
- ☐ Healthcare Power of Attorney

Does the applicant have a hospital preference? ☐ Yes ☐ No

If yes, please list the hospital: _____

Does the applicant have hospital insurance in addition to Medicare/Medicaid? ☐ Yes ☐ No

Activities of Daily Living – The following are things we do in our day to day lives. Please check is 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 they have 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.

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

Release of Information

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

I also allow release of information necessary for The Life Center 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, Inc. to assist the applicant's taking of their medications prescribed by their physician.

I give my permission for emergency treatment as deemed necessary by The Life Center staff or emergency personnel.

I give permission 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 their office or emergency room.

Consent to Photograph

I give permission to The Life Center of Davidson County, Inc. for _____ to be photographed for the purpose of promoting the services of The Life Center in newspaper articles, slide or video presentations, social media, newsletters, or television stories. 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 Participant and Family 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.

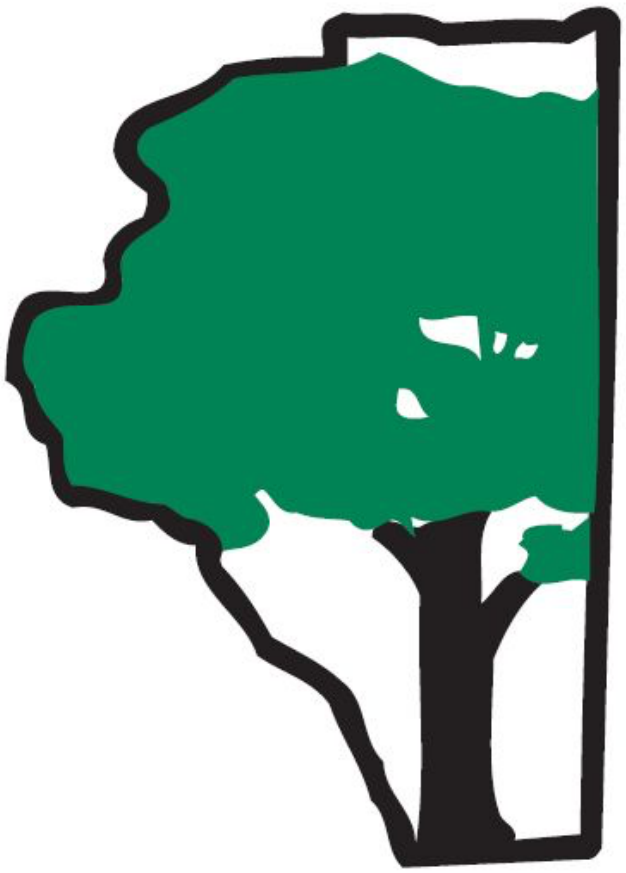
Applicant's Name (Printed): _____

Applicant's Signature: _____ Date: _____

Responsible Person Name (Printed): _____

Responsible Person's Signature: _____ Date: _____

The Life Center Staff Signature: _____ Date: _____



A Day Program for Adults at

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of Davidson County, Inc.

Inquiry Packet

The Life Center of Davidson County, Inc.
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 care/day health program setting.

Our Goals

The Life Center's goals are:

- To provide stimulating activities for participants.
- To provide a supportive environment which fosters increasing a participant's feeling of self-worth while preserving their dignity.
- To support participants to maintain and achieve maximum personal independence and functioning.
- To provide health services to enhance care provided by the participant's physician and family.
- To provide a warm, loving, nurturing environment to enhance the quality of life of participants.
- To encourage companionship and friendship among participants.
- To encourage participants to experience new activities.
- To provide a safe place for caregivers to leave their family member during the day.
- To assist a family in the goal to keep a loved one at home.
- To provide a time of respite for the caregiver.
- To offer the community a quality service that is affordable.
- To make referrals to other organizations when The Life Center is not or is no longer appropriate.
- To create an atmosphere which supports, involves, and validates the participant.
- To have an emphasis on health, rather than illness, and on maximizing the quality of the participant's life.

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

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. You can:

- Come by The Life Center anytime during our business hours of 8:30am-4:30pm. We are located at 601 West Center Street, Lexington, NC 27292.
- 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 questions. 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. 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, 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 has limited funds for transportation through a grant funded from the North Carolina Department of Transportation. If transportation is needed, please request it when applying for enrollment.

Costs

The Life Center's fees are based on the cost of providing care. 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 schedule a visit to The Life Center to complete the enrollment process.

The enrollment process is designed to give the applicant, their 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 TLC facility. Therefore, **the applicant should accompany the family** to The Life Center for this visit. The family should allow about 90 minutes. At enrollment, a $25.00 application fee and any other applicable fees may be due.

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, devotions, trivia, trips down memory lane, games, and more. Safe 'wandering' is permitted within the building and onto the screened porch, as weather permits.

Activities are planned and paced for 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 care/day health setting. If you have questions about a specific health care need, or our ability to meet that need, please contact us.

- 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 program.
- Is not disruptive, is not verbally or physically harmful to others.

Health Care Services

Health care staff assist the participant with taking medications, following special diets, walking and moving about the center, monitoring their health with monthly health checks, maintaining mobility through individualized range of motion exercises, a bowel and bladder program, and more. Additional fee-based services include: daily/weekly health 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 hours are **7:30 a.m. to 5:00 p.m.**

A Typical Daily Schedule

Morning	7:30 – 8:50	Weather and News – Social Time
	8:50	Thought for the Day and Pledge
	9:00	Breakfast
	9:30	Morning Exercise
	10:15	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 or 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
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