



2026

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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, Family Member or Responsible Person:

Attached is an application for participation in the adult day care/adult day health program of The Life Center. The information on this application is confidential and will be used to enable our staff and Quality Assurance committee members to assess whether The Life Center can provide the level of care requested. The Scholarship Application is attached for those enrolling in the Scholarship and Subsidy Program. The financial documentation will be used only to determine eligibility and will be returned with the decision letter.

Upon receipt of the application form and medical form (which is to be completed by the applicant's physician), the family should call to schedule an interview with me. 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 The Life Center. If applicable, the scholarship application should be sent to The Life Center with the required documents. Please see the scholarship application within this packet for more details.

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.

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? *Choose all that apply.*
☐ Enrichment ☐ Cognitive Stimulation ☐ Socialization ☐ Respite ☐ Caregiver Support
☐ Care During Employment ☐ Other (specify): _____
- 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? ☐ Partner, ☐ Adult Child, ☐ Self, ☐ Other: _____
- Name of person participant lives with: _____ Number of people in the household: _____
- What was the participant's past job(s)?
- 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 the responsible person for the applicant (overseeing care, finances, 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: _____

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:			

In the event of an emergency:

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

- ☐ A Living Will
- ☐ Do Not Resuscitate Orders (DNR)
 - If yes, please provide an original gold DNR form from your physician.
- ☐ Advance Directives
- ☐ Healthcare Power of Attorney
 - If yes, please provide a notarized copy of the Healthcare Power of Attorney document.

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 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 they have to go to the bathroom and are 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.

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 themselves.
- ☐ The applicant is on a special diet. If so, what type?
 - ☐ No Added Salt, ☐ Low Salt, ☐ Diabetic, ☐ Ground Foods, ☐ Other (specify): _____
- ☐ The applicant has problems with choking. How frequently? _____

Additional Information about the Applicant cont.

- ☐ 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 hearing aids.
- ☐ 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, ☐ other (specify): _____
- ☐ The applicant needs assistance with ambulation.

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

About Transportation

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

If yes, who will provide transportation? ☐ Relative or Caregiver ☐ Participant ☐ Other (specify)

Name of person providing transportation: _____

If no, do you need for transportation to be arranged, if available? ☐ Yes ☐ No

Prospective Monthly Attendance Schedule – please fill in your requested days for a monthly schedule.

WEEK 1	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
WEEK 2	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
WEEK 3	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
WEEK 4	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
WEEK 5	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					

About the Applicant's Doctor and Dentist:

Name of Primary Care Physician: _____

Mailing Address: _____

Phone Number: _____

Name of Dentist: _____

Mailing Address: _____

Phone Number: _____

If you have more than one physician or other specialist (neurologist, cardiologist, gastroenterologist, etc.), please attach a list of physicians to this application.

Name of Specialist: _____ Specialist Type: _____

Mailing Address: _____

Phone Number: _____

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 ☐ NoDoes the applicant have any drug allergies? ☐ Yes ☐ No

If yes, please list: _____

FINANCIALS

Please remember The Life Center in any honorariums and memorials for your care recipient as donations enable The Life Center to continue providing scholarships and services to future participants.

NOTE: If the care recipient and/or caregiver will pay for the full cost of services, NO financial information is required.

Does the care recipient have a long-term care policy? ☐ Yes ☐ No

- **If the care recipient has a long-term care policy that reimburses for adult day services, they are ineligible for grant scholarships.**
- Please let us know if you need documentation to support filing your claim.

If you would like to apply for scholarship funding, please complete the green Scholarship Application form in your Inquiry Packet. Scholarship funds at The Life Center are limited and therefore allocated based on need basis. Awarding of scholarship funds is based on the information provided by the applicant on the application form and supporting documents.

The information in the Scholarship Application form will be used by The Life Center to document the recipient's eligibility for scholarship funding. **All information will remain confidential.**

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.

Please return the following documents by U.S. mail or in person to:

The Life Center of Davidson County, Inc.
601 West Center Street
Lexington, NC 27292

- ☐ Completed Family and Participant Information Form (Pink Form)
- ☐ Medical Form (Gold Form) – Completed by the primary care physician
- ☐ Completed Scholarship Application (Green Form) *(if applicable)*
 - ☐ Three most recent bank statements
 - ☐ Most recently filed federal and state tax returns

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
The Life Center
of Davidson County, Inc.

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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

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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: _____

Address: _____

Phone: _____ Fax: _____



Scholarship Application for The Life Center of Davidson County, Inc.

Scholarship funds at The Life Center are limited and therefore allocated on an as needed basis. Awarding of scholarship funds is based on the information provided by the applicant on the application form and supporting documents.

The following information must be completed and submitted along with the required documentation for the scholarship application to be considered.

Participant Name: _____ Caregiver Name: _____

Desired number of days to attend per week: _____

Please complete the following information representing the income of the participant and partner/spouse (if any); attach an additional sheet if necessary.

MONTHLY INCOME	PARTICIPANT	PARTNER/SPOUSE
Pension	\$	\$
Social Security	\$	\$
Family Support	\$	\$
Interest (bonds, stocks, savings)	\$	\$
Dividends & Capital Gains Distribution	\$	\$
Retirement Benefits	\$	\$
Estates	\$	\$
Trusts	\$	\$
Royalties	\$	\$
Rental Property	\$	\$
Employment Wages	\$	\$
Unemployment Benefits	\$	\$
Worker's Compensation	\$	\$
Alimony	\$	\$
Other	\$	\$
TOTAL INCOME:	\$	\$

Please add any comments or extenuating circumstances regarding your finances: _____

TERMS AND CONDITIONS; (1) All awards from the Scholarship Fund are in the form of reduction of fees for program services provided by The Life Center. No cash awards are made. (2) The Life Center makes awards at its sole discretion based on applicant need, financial and program resources of The Life Center, and such other considerations as The Life Center may deem appropriate, as determined and approved by The Life Center Board of Directors. (3) A potential participant whose application has been denied may reapply if their financial condition changes. (4) The Life Center will review the financial status of awardees once per year and may ask for updated financial information. The Life Center may terminate the award if the responsible party fails to provide requested information in a timely manner. (5) The Life Center will terminate the award immediately if discrepancies are discovered in the financial information presented in this application or subsequently. (6) The responsible party shall notify The Life Center within 10 business days of any material change in the applicant's financial condition. (7) The Life Center has the right to increase, reduce, or terminate awards at its sole discretion when it deems necessary. (8) All decisions of The Life Center regarding the Scholarship Fund are final. (9) The participant, spouse, and responsible party (if any) agree to hold The Life Center harmless for all decisions regarding the Scholarship Fund. All recipients are to maintain a current account balance. Families with past due amounts of greater than 30 days may be suspended from program activities until the past due amount is brought current.

By signing below, I (print name) _____ certify that the information provided on this application accurately reflects the participant's financial situation. I understand that if discrepancies are discovered, financial assistance will be stopped immediately.

Signature of Responsible Party

Date

Please attach the following documents:

- The Scholarship Application **must include** the supporting documents prior to submission to Scholarship Committee
- ☐ Three most recent bank statements that document income as noted on the previous page
- ☐ Most recently filed federal and state tax returns

Please return the following documents by U.S. mail or in person to:

The Life Center of Davidson County, Inc.
601 West Center Street
Lexington, NC 27292

- ☐ Completed Scholarship Application (Green Form)
 - ☐ Three most recent bank statements
 - ☐ Most recently filed federal and state tax returns
- ☐ Family and Participant Information Form (Pink Form)
- ☐ Medical Form (Gold Form)

A determination whether to award a scholarship will be made within 14 days of the time the completed application is submitted. The Life Center will notify an applicant of the decision by letter, including effective date, via USPS mail or email.

For questions, please contact us at 336-249-2155 or email us at info@lifecenterdavidson.com

COMPLETED BY THE LIFE CENTER STAFF ONLY

Date Application Received by The Life Center: _____

Staff Initial: _____



*A Day Program
for Adults at*

**The
Life
Center**

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 maintaining and achieving 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

