GrandFriends Adult Day Services

Via! Community Center
Health, Fitness & Enrichment
For Active, Older Adults

**1717 Dauphin Street**
**Mobile, AL 36604**
**251-478-3311**

GrandFriends Adult Day Program is a community service program of Via Health, Fitness and Enrichment Center. This program is designed to offer caregivers an affordable opportunity for respite while providing supervised activities within a safe, healthy and comfortable environment. The program is for any adult over the age of 50 in need of moderate assistance and supervision. The staff includes Certified Nursing Assistants, senior aides, senior companions and trained volunteers.

**Care-partner Benefits include**:
* Opportunities to shop, take personal time, attend a special event or work outside the home.
* Peace of mind knowing the person attending the program will be in a caring, activity-filled and safe environment.

**Member Benefits include:**
* Individual and group activities that promote mental functioning and physical participation.
* Increased socialization can reduce feelings of isolation.
* Meals in a group setting can improve nutritional status.
* Improved sleep patterns usually occur with increased activity.

**Eligibility Requirements:**
* 50 years of age or older
* Requires supervision.
* Able to eat independently with minimum assistance.
* Non-combative and will accept direction.
* No wandering or exit-seeking behaviors.
* Is not completely incontinent.
* Able to transfer independently or with minimum assistance of one person.
* Clean and well groomed upon arrival.
* Able to take own medications correctly or medications not needed while attending program.
* Able to stay out of bed 6-8 hours a day.
* Passes the screening assessment and ½ day trial day.

Program is open from 7:00am to 5:30pm Monday thru Friday excluding holidays.
For more information call Chelsea Stein; GrandFriends Program Supervisor : 251-470-5228 or e-mail; cstein@viamobile.org.

**Application Process:**

1. Complete the application and return to the Via Center.
2. After reviewing your application, the Program Coordinator will call you to schedule an appointment for a confidential interview to determine eligibility. The prospective participant will need to attend this interview.
3. After the tour and interview, a half-day trial day will be scheduled. This allows the participant to become familiar with the program and completes the assessment process.

A non-refundable $25.00 assessment fee is payable at the time of the interview.
If accepted into the program, a $60.00 annual membership fee** is due before the first full day of service.
**This fee may be paid for by your insurance plan. Please see our Welcome Desk to inquire.

**Confirmation of the individual's placement**: If an individual does not attend within 30 days of the initial interview and acceptance, the individual will be discharged from the program and must go through the application process again.

An assessment will be conducted by the Program Coordinator during the introductory period.

GrandFriends reserves the right to dismiss any participant at any time, who after reasonable interventions demonstrates an inability to participate in our program, or whose presence is detrimental to the group.

**Important Numbers to Know:**

- Chelsea Stein – Program Supervisor 251-470-5228
- Linda Bush – Program Coordinator 251-470-5228
- Deanna Murphy – Executive Director 251-470-5232
- Via Information Desk/Welcome Center 251-478-3311

**Daily Schedule**: 7:00 AM – 5:30 PM
**Participants must be picked up by 5:30 PM. **A fee will be charged after 5:30 at the rate of $2.00 per minute, timed by the Center's Time Clock**.

**Holiday Schedule**
**The Grandfriends' Program will be CLOSED on the following days:**

| |
|---|
| New Year's Day |
| Martin Luther King |
| Mardi Gras |
| Good Friday |
| Memorial Day |
| Independence Day |
| Labor Day |
| Thanksgiving Holidays-TBD |
| Christmas Holidays-TBD |
| New Year's Eve |

**Program Fees**: $25.00 Application, interview and trial day fee.
$60.00 Annual Membership Fee.
$50.00 per day if the member attends more than one day per week.
$55.00 per day if the member attends only one day per week.

- **PAYMENTS**
  - Payments are made in advance of participant's attendance
  - All accounts must be kept current in order for continued participation in program
  - Payments will be made upon arrival on the first day of attendance for that week
  - Invoices will be sent our weekly
- **FEES** There is an Annual Membership fee of $60.00* payable as soon as the participant is accepted into the program and before their first full day of attendance.
  ***All charges are subject to change.**
- **ATTENDANCE** Participants may attend 1 to 5 days in the week. Attendance is required at least one day per week. Enrollees must give the day/days of the week they will attend in order to ensure proper staffing. If a participant is absent on a day they are scheduled to come, 24 hours notice is required. If proper notice is not given, participants may be charged for any scheduled days they did not attend.
- **RE-ENROLLMENT** If the participant does not attend for more than 3 months, they will be required to reapply and be reassessed. They will be charged a $25.00 application and interview fee as well as the $60.00 annual membership fee if it has lapsed.
- **CHANGING DAYS** Approval for switched days may be obtained from the Program Coordinator.
- **HALF-DAYS** Unless it is the initial Trial Day, the GrandFriends Adult Day Program charges the daily fee regardless of the number of hours a participant attends. We are unable to charge half-day or hourly rates.
- **TRANSPORTATION** The Via Center does have a handicap accessible van that provides transportation within a 10 mile radius for $3.00 per one-way trip. Transportation will be arranged and scheduled with the Drivers.

**Daily Fee Includes:**

Breakfast, Lunch and Snacks
Most Activity Supplies
Special Events, some outings and parties

**What To Bring:**

1. A complete change of clothing (including underwear and socks) is needed. Please label each item with the participant's name. Even participants who do not have toileting accidents occasionally have spills or become ill and will be more comfortable changing into his or her own clothes. These items will be kept at the Via Center in the participant's assigned bin.
2. Label wheelchairs, walkers and canes.
3. Families must provide their own disposable undergarments for participants. Please label the package with the participant's name and check with nursing assistants monthly to see if items need to be replenished.

## I have read the above information and agree to follow:

_____ _____

**Signature of Caregiver** **Date**

**GrandFriends**
**An Adult Day Program**
**1717 Dauphin Street**
**Mobile, Alabama 36604**

**Date: _____**

Member's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Birthday: _____

**Emergency Contacts**

We must have ***immediate*** notification, in writing, of address, phone and job changes so that we can notify you in case of an emergency.

*Name _____ Relationship_____
Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____
E-Mail _____ Cell Phone _____

Name _____ Relationship_____
Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____
E-Mail _____ Cell Phone _____

Name _____ Relationship_____
Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____
E-Mail_____ Cell Phone _____

(*) Denotes the person who correspondence and/or bills should be sent to.

**Physician Contact**

Physician's Name _____ Phone _____
Preferred Hospital _____
Insurance Information _____

**Attendance Schedule (Circle Days) (Participant cannot change dates without approval)**

Monday Tuesday Wednesday Thursday Friday

**Individual Completing Application – I understand that my participant will be billed for days scheduled, regardless of the attendance.**

Signature _____ _____ __ Date_____ Relationship _____

Program Representative:
Signature _____ _ Date_____ Position_____

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**Health Profile**

Participant's Name _____Birthdate_____

Medical Diagnosis – Current: _____

Medical Problems – History: _____

Allergies: (Food, Medicine, Other)_____

**Circle All That Apply:**

Mental Problems: Short-term Memory Long-Term Memory Confusion Wandering

Behavioral Problems: Hostile Danger To self Danger To Others Yelling Crying

Any Assistive Devices Used or Needed: Walker Cane Wheelchair Rolling Walker Restroom Rails

Restroom Assistance Needed: Transfer Clothes Removal Reminders Special Undergarments

Special Food Restrictions/Likes or Dislikes: _____

Physical Activity Restrictions: _____

Will Participant Need to Take Medications at Program? Yes_____ No_____

**Symptoms**
Has the participant ever had a positive test? Y N If yes, when? _____
Has the participant had any of the following symptoms lately?

| | | | | | |
|---|---|---|---|---|---|
| Loss Of Appetite | Y | N | Hoarseness | Y | N |
| Chest Pain | Y | N | Fever | Y | N |
| Excessive Fatigue | Y | N | Night Sweats | Y | N |
| Shortness of Breath | Y | N | | | |
| Falls | Y | N | If yes, when?_____ How?_____ | | |
| Weight Loss | Y | N | Usual Weight _____ Present Weight _____ | | |
| Productive Cough | Y | N | If yes, color _____ Amount per day _____ | | |

I certify that to the best of my knowledge, above named participant is free from contagious diseases, and that the above information is accurate and complete. I understand that the above named participant may be required to undergo a physical examination by their doctor before entering the program.

Signature _____Relation_____ Date _____

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## Release for Emergency Medical Treatment

I, the undersigned, give consent for Via (Senior Citizens Services, Inc.) to seek emergency medical treatment for _____ (Participant's Name) in the event that it becomes necessary and to release basic data, medical information and advanced directives information to the emergency personnel attending the participant. The staff of Senior Citizens Services, Inc. will make every effort to reach the emergency contacts listed on the application.

Do you have Advanced Directives (Living Will, Durable Power of Attorney)? Y N
**If yes, please include copy with this application.**

Signature _____ Date _____

Witness _____ Date _____

## Photo Release

I, (participant's name) _____give my permission for my photograph to be taken and used through Senior Citizens Services, Inc. programs. I understand that any photographs taken individually or as part of a group may be used to promote the programs of Senior Citizens Services, Inc. Examples of such promotion would include newspapers, agency newsletters, public displays, brochures, etc.

Signature _____ Date _____

**OR**

I would NOT like for (participant's name) _____to be photographed for program use.

*Please note that a headshot photo will be taken of the participant for staff identification purposes only.

Signature _____ Date _____

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**Visitor(s) Release**

I, the undersigned, give permission for the following person(s) to visit with and remove (participant's name) _____from the program. I understand that Via will only allow the person(s) listed below to visit and remove them from the program unless I provide written notification of others.

►Name: _____visit ___remove___

►Name: _____visit___remove___

►Name: _____ visit___remove___

►Name: _____visit___remove___

I understand that while the above named have my participant out of the daycare program, that no employee or volunteer of Via (Senior Citizens Services, Inc.) will be responsible for said named participant.

Signature: _____ Date _____

Witness: _____ Date _____

There are **no restrictions** on who may visit: _____

Signature: _____ Date: _____

Comments (please note if there are any persons NOT authorized to visit or remove participant):

_____

_____

_____

_____

_____

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Participant's Name _____Date _____
Address: _____ City/State/Zip _____

Please list the names and numbers of those individuals allowed to pick up day care participant. **Complete all information if not already listed as emergency contact**.

| | | |
|---|---|---|
| 1. Name | | Relationship |
| Home Phone | Work | |
| E-Mail | Cell | |
| 2. Name | | Relationship |
| Home Phone | Work | |
| E-Mail | Cell | |
| 3. Name | | Relationship |
| Home Phone | Work | |
| E-Mail | Cell | |
| 4. Name | | Relationship |
| Home Phone | Work | |
| E-Mail | Cell | |

## Medication Profile-*Please update as medications change*

| Name of Medication, Dose and Frequency | Reason for Medication | Month/Year Began | Physician |
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* Continue medications on page 2

***Staff may NOT administer medications; they may only remind participants of the instructions.**

Signature of person completing the application: _____

Relationship: _____Date: _____

**Medication Profile** (Continued) Name: _____
Date:

| Name of Medication, Dose and Frequency | Reason for Medication | Month/Year Began | Physician |
|---|---|---|---|
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**Activities/Interests Profile**

Date: _____

Participant's Name _____

Former Occupation_____

Single Divorced Widowed

Religion_____ Highest Education_____

No. of Children_____ No. of Grandchildren_____ No. of Great Grandchildren_____

Do You Live: Alone With Spouse With Family Assisted Living Nursing Home
Other_____

Clubs/Memberships – Past and Present_____

_____

_____

_____

Hobbies - Past and Present _____

_____

_____

_____

| | | | | | |
|---|---|---|---|---|---|
| Sewing/Knitting? | Y | N | Movies? | Y | N |
| Arts & Crafts? | Y | N | Cooking? | Y | N |
| Gardening? | Y | N | Exercising? | Y | N |
| Dancing? | Y | N | Word Games? | Y | N |
| Puzzles? | Y | N | Outdoors | Y | N |
| Sports | Y | N | Reading | Y | N |
| Current Events | Y | N | Card Games | Y | N |

What would you like Grandfriends to help with? (Circle Those You Consider Most Important)

Socializing Caregiver Respite Maintaining Independence Exercise