



Marianne's House

Marianne's House Day Activity Center

Enrollment Packet

Mission Statement: To offer quality care and quality options to adults with developmental disabilities, and to their care providers and family. Our program is based on social, recreational, life skills and pre-vocational activities. All craft days are open to community participation. Also, our shuttle is used to access community events on a regular basis.

Guiding Principles: To provide a place where adults with developmental disabilities can come for the day to participate in day programs designed to cultivate life skills used in vocational, social and recreational settings. This time will allow caregivers of these individuals the time and flexibility for other activities and responsibilities.

Marianne's House is a non-profit 501© (3) organization dedicated to improving the care and quality options for adults with developmental disabilities and their care providers.

Welcome Letter

Dear Future Client and Caregiver/Guardian,

Thank you for your interest in Marianne's House Day Activity Center. We are sending you the necessary forms to read, fill out, sign and mail back so that we can review your information for the enrollment of your loved one.

As the first non-profit Day Activity Center in Whatcom County, we're excited to serve you and your family. We have a great Board of Directors that has worked hard to help Marianne's House become a reality. There are extraordinary individuals and organizations that have donated time, effort, and resources to make it possible to serve you in the most economical manner. Currently we are being hosted at the First Christian Church on 495 E. Bakerview in Bellingham.

We look forward to meeting and welcoming you to Marianne's House. Please contact us with any questions. Thanks in advance for your quick response.

Scott Watts
Program Director
Marianne's House
360-756-5232

Required Agreement/Release Forms

It is the responsibility of the client or caregiver/guardian to ensure the enrollment packet agreements/forms are submitted to the Site Manager for acceptance review no later than one week prior to enrolment.

1. Services Contract
2. Financial Agreement of Understanding
3. Release and Hold Harmless Agreement
4. Client's Health / Intake History
5. Emergency Medical Release Form
6. Authorizations, Agreements, and Procedures

Once you have completed all forms, please mail them to:

Marianne's House
Attention: Admittance
P.O. Box 29421
Bellingham WA 98228

Upon receiving all of these forms, we will consider your loved one for enrollment. We thank you for your interest and if you or someone you know desires to be a future volunteer, please e-mail us at: marianneshouse@aol.com

Thank You,

**Scott Watts
Program Director
Marianne's House**

Service Contract

Client name: _____

Address: _____

Please circle the day(s) attending: M W F

Additional Payee(s): _____

Billing Address: _____ City/State: _____

Home Phone: _____ Work Phone: _____

Transportation By: _____

Please circle one: Caregiver Guardian Parent

Please list additional transportation names: _____

Caregiver/Guardian contact information (how can we reach you if the need arises?):

If Caregiver/Guardian not available, emergency contact #1 information:

If emergency contact #1 not available, emergency contact #2 information:

I have read, understood, and agree with the information given on this form. I release Marianne's House Day Activity Center and all its agents from any liability for any accident, injuries or damage of any kind to persons or property that might occur while participating in the Centers activities.

Signature of Participant/Caregiver

Date

Financial Agreement of Understanding

I understand that as the family member/guardian, it is my responsibility to notify Marianne's House Day Activity Center if my loved one will not be attending, or if any difficulties, or changes in health status occurs.

- I understand that the rate is \$9.50 per hour. I will be billed monthly according to attendance, by the Marianne's House. The schedule for attendance will be supplied to the manager by the end of the month for the following month. All payments are due at the 1st of the month for the up coming month. All payments are to be clearly marked with the Clients name on the check or a copy of the invoice, and mailed to Marianne's House at P.O. Box 29421, Bellingham WA 98228. If the client is enrolled in the middle of any billing cycle, the monthly rate will be pro-rated and is due on the first day of service. Client account must be paid in full and received no later than the last day of the month prior to attendance to avoid a late fee.
- A late fee of \$25.00 will be assessed to the client's account if payment is not received by the last day of the month.
- Checks received by Marianne's House, which are returned by the bank, will incur a \$25.00 charge in addition to the late fee. Services will then be withheld until account is paid in full.
- I may choose to drop off my loved one on a day other than our regular schedule. Attendance on non-scheduled days is accepted at the "Drop In" Rate of \$10.00 an hour if space is available.
- Your next month's schedule of days you or your loved one plans to attend is due to the Marianne's House Day Activity Center staff by the end of the month.

Date: _____

Client or Caregiver/Guardian

Marianne's House Staff Member

*** We are also contracted Respite Care providers with DSHS and NW Regional Council ****

Release and Hold Harmless Agreement

Please read carefully before signing

I Hereby Agree As Follows

1. TO ASSUME AND ACCEPT ALL RISKS, DANGERS AND HAZARDS in connection with my use and my guardians use of the facility.
2. TO WAIVE ANY AND ALL CLAIMS that I may have against Marianne's House of Whatcom County and property owners as a result of my use of and presence at the facility.
3. TO RELEASE Marianne's House of Whatcom County, it's employees, volunteers, clients, property owners, Board of Directors and all people present and/or involved with the property and program from any and all liability, rights of action or caused of action arising out of contract, tort or otherwise for any loss, damage, injury or expense that I, my next of kin or my ward may suffer or incur as a result of my use of the facilities due to any cause whatsoever.
4. THE UNDERSIGNED AGREES TO HOLD HARMLESS AND INDEMNIFY Marianne's House of Whatcom County and any employees, volunteers, agents, students, and visitors of Marianne's House of Whatcom County from any and all liability for personal injury, property damage or death suffered by myself or by a third party as a result of my use and presence at the facility.
5. That In The Event Of My Or My Minor Child's Injury or Death, Or Of The Injury And Death Of My Ward(s), THIS RELEASE AND INDEMNITY AGREEMENT shall be effective and binding upon my heirs, next of kin, executors, administrators and assigns in relation to the Marianne's House Day Activity Center of Whatcom County, its property owners, and any and all people involved.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THIS RELEASE AND INDEMNITY, I am 18 years or older, I HAVE THE AUTHORITY AS THE CLIENT AND/OR GUARDIAN (PLEASE PRINT CLIENTS FULL NAME)

_____ TO SIGN AND RELEASE ON BEHALF OF THE CLIENT SO THAT THE CLIENT PARTICIPATE, AND USE THE FACILITIES OFFERED BY Marianne's House of Whatcom County. I am aware that by signing this document I am affecting the legal rights and liabilities of the client, his or her next of kin, executors, administrators, and assigns in relation to Marianne's House Day Activity Center of Whatcom County and all people involved with the Marianne's House Day Activity Center of Whatcom County.

Name of Guardian (Please Print):

Signature of Guardian

Date

Client's Health / Intake History

Date: _____

Client's Name _____ Date of Birth _____

Address: _____ Phone: _____

City/State: _____ Social Security Number: _____

Physician's Name: _____ Phone: _____

Date of Last Physical Exam: _____

Diagnosis: _____

Client's Condition: _____

Medical Insurance Company _____ Policy # _____

Type of Insurance _____

In order for us to have a more accurate history, please complete the following information about the prospective client. All information given below will further assist medical personnel in case of an emergency.

Section 1

Immunizations:

Tetanus shot within last 5yrs Pneumonia Vaccine Flu Shot

Medications:

Independent _____ Assist _____

Clients are responsible for administering their own medications. Staff can only provide reminders and assistance. **Medications can only be given by a family member, RN, or LPN.** Please consider either utilizing a pill minder while at the facility or giving any medications before or after your loved one is at the facility.

Continued on next page.....

Medication **Dosage** **Times Per/Day** **Condition for Prescription**

- 1.
- 2.
- 3.
- 4.
- 5.

If there are adaptations to frequency and/or manner in which medications can be taken if patient has difficulty doing so on his/her own, please specify.

Section 2

Does the client *currently* have any of the following conditions?

Allergies (Yes / No) If yes, please list:

Nervous System (Yes / No), if yes, please specify:

Epilepsy or Convulsions Migraine or frequent Headaches Fainting Spells
Paralysis (loss of motion) Dizziness Numbness/Loss of Sensation

Respiratory System (Yes / No), if yes, please specify:

Hay Fever/Asthma Chronic or Frequent Cough

Cardiovascular System (Yes / No), if yes, please specify:

Extreme tiredness/Fatigue Palpitation or Fluttering Heart
Other (please explain):

Genitourinary System (Yes / No), if yes, please specify:

Difficulty urinating Prompting for Restroom Rest Room Assistance
Incontinence/undergarment

Diet (Yes / No), if yes, please specify::

Difficulty swallowing Difficulty cutting foods

Is the client on a special or restrictive diet? _____

Section 3

Communication: _____

Communication Limitations? _____

Primary Language: _____

Mobility:

Walk with Assistance Some Assistance No Assistance

Wandering Tendencies:

Never _____ Sometimes _____ Often _____

Toileting:

Independent _____ Continent/Need Assist _____ Incontinent/Need Assist _____

Communication:

Aphasic _____ Clear Speech _____ Sign _____

Behavior:

Calm _____ Frustrated _____ Angry _____

Explain:

Daily Routine/Needs:

Special Instructions:

Please list below all other health concerns/needs. All information given below will further assist medical personnel in case of an emergency.

Date: _____

Caregiver/Guardian: _____

Emergency Medical Release Form

(Form for clients and volunteers)

If Emergency Medical Care is required for _____ in conjunction with Marianne's House of Whatcom County, and if the Normal permission isn't available in a timely manner, the undersigned authorizes emergency medical personnel to provide emergency medical care and consents to treatment by physician and at medical facilities.

Please fill out this section if the information has not been previously provided.

Client/Volunteer _____ Home Phone _____

Address _____

If not available, contact _____ Phone _____

Physician _____ Phone _____

Participant takes the following medications _____

_____ For _____

Allergies _____

Clients Date of Birth _____ Age _____

Medical Insurance Company _____ Policy # _____

Type of Insurance _____

I Have Read This Entire Release and Agree To It.

I know by doing this, I relinquish all claims I may have against Marianne's House of Whatcom County, all members of its organization.

Signature: _____ Date: _____

(Signature of Guardian or Caregiver if Client is unable to give Signature)

Non-Consent Plan (Cross out following section if you do not sign it)

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of volunteering, receiving services or while being on the property. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Non-Consent Signature: _____

Print Name: _____ Phone: _____

Address: _____

Authorizations, Agreements, and Procedures

Please circle yes or no and initial.

Photo Authorization (Yes / No) _____ :

I hereby grant permission to Marianne's House to photograph/video my loved one, for the purpose of program activities, promotions, and releases.

Trip Authorization (Yes / No) _____ :

From time to time, Marianne's House will take small trips within the community on the Marianne's House Shuttle.

We, as Caregiver/Guardian, understand that this activity, as in any activity, does present the risk of injury to the participant, therefore, we have discussed with the participant those possibilities. We represent to you that we and the participant assume the risk of any such injury and hold you, your agents, employees, and representatives harmless from any liability to any other person or entity arising as a result of the conduct of the participant in this activity and agree to defend and identify you, your agents, employees, and representatives against any claim or liability arising as a result of such contact.

If we, as Caregiver/Guardian, are not personally present at these activities in which the participant is to partake, so as to be consulted in the case of necessity, you are authorized on our behalf to arrange for such medical and hospital treatment as you may deem advisable for the health and well being of the participant. The participant has insurance and is under supervision of the Staff at Marianne's House.

Food and Meal Agreement (Yes / No) _____ :

Our goal at Marianne's House is to assist and encourage our clients to develop and increase their meal preparation abilities. We will support the client to further advance their abilities in the kitchen with food preparation; baking and the occasional special cooking project. Marianne's House does not provide lunch due to each individual's unique dietary needs. The client needs provide their own lunch that we can assist them to get ready or warm up for themselves.

Wandering Policy/Procedure (Yes / No) _____ :

I have read the Policy/Procedure for Critical Wandering (Appendix A) included in this packet. I understand that Marianne's House Adult Day Activity facility has exits that must remain unlocked in compliance with the Fire Code. I understand that although Marianne's House staffs adequately for the type of clientele each day, clients have the potential to wander away from Marianne's House facility undetected. I also understand that due to the nature of the reasons that bring people to need adult day care services, clients have the potential to begin wandering behavior at any time even if there has been no previous wandering behavior. I also understand that the Administration of Marianne's House is always assessing the clients for behavior changes, disruptive behavior/dangerous behavior, etc. and will contact me to discuss all changes

Enrollment/Discharge Procedure (Yes / No) _____ :

I have read and agree with the Policy/Procedure for Continued Enrollment (Appendix B) included in this packet.

Date: _____

Client's Name: _____

Caregiver/Guardian: _____

Appendix A

Critical Wandering

POLICY:

1. Facility staff/volunteers will take precautionary measures to prevent clients from wandering, however in the event that a client wanders away from the facility, all efforts will be made to locate and recover such clients.
2. All persons inquiring about Marianne's House services will be informed of the facility having three (3) unsecured exits and the facility staff/volunteers cannot guarantee that clients will not wander from the facility unaccompanied/undetected, but that all precautions will be taken to ensure client safety while attending the facility.
3. Caregivers/guardians will be given a copy of the policy and procedures for wandering upon client enrollment.
4. Caregivers/guardians will be required to sign the Wandering Policy/Procedure Signature Sheet upon client enrollment.

PROCEDURES:

In the event that a client wanders away from the facility, the following steps will be taken:

1. The Site Manager will make all necessary measures to ensure the other clients are adequately supervised (kept safe) while available volunteers and staff begin an area search on foot and/or in vehicles.
2. The Site Manager will initially contact the following and provide appropriate information:
 - ◆ Call 911/EMS, giving a description of the client, how long they have been missing, and their medical condition;
 - ◆ Notify Whatcom Transit @ 676-7433
 - ◆ Call the client's caregiver/guardian to report the incident and steps taken to recover the client.

3. If the client has not been recovered within thirty (30) minutes, the Site Manager will:
 - ◆ Notify the local radio station KGMI AM 790 @ 734-9790
 - ◆ Pull the chart with the client's picture and have that ready for EMS and other searchers to view.
4. The Site Manager shall remain available by phone until such time as the client is located to make notation of who is called and the time they called.
5. The Site Manager and involved staff will fill out an incident report, to be completed no later than closing the following day.
6. The Executive Director and/or Site Manager will follow up with the client's caregiver/guardian in the workweek following the incident to report on continued steps taken to prevent further critical wandering incidents.
7. The Executive Director and/or Site Manager will hold a staff meeting within five working days to review the incident, our system in place, staff responsibilities and how to prevent a recurrence of critical wandering incidents.
8. All clients who are critical wanderers will be evaluated on a continuous basis for and discussed with the family about, appropriateness in the Program. A client will be discharged from the Program when his/her critical wandering is so excessive it has become disruptive to the other clients, and/or the Executive Director and/or Site Manager feel the client is beyond the Program's ability to keep him/her safe.

Appendix B

Continued Enrollment

POLICY:

Continued enrollment is based on regular assessment of client participation, independence, interaction, and disruptive behavior/dangerous behavior.

PROCEDURES:

1. All clients will be evaluated on a continuous basis regarding appropriateness in the program.
2. In the event that a client is harmful to themselves or others, the following procedures will take place:
 - a) The client's caregiver/guardian/emergency contact will be notified immediately for client pickup,
 - b) Documented medical intervention is compulsory before consideration of re-entry into the program.
3. A meeting with the caregiver/guardian will take place to discuss possible explanation and solutions for clients' continued enrollment.
4. If no acceptable solution is attained, the Site Manager and/or Executive Director will hold a staff meeting regarding clients' continued enrollment.
5. Client discharge from the program will be based upon client evaluation and staff recommendations.

The caregiver/guardian will be informed in writing of client discharge within two (2) weeks of staff decision.

Consent for Release of Information

(see WAC 388-71-0744)

I, Name: _____

Address: _____

City/Town: _____

Zip Code: _____

Telephone: _____

give consent to the Marianne's House staff to release relevant information regarding

_____, a client of Marianne's House, to _____

for the purpose of _____. *This consent form is valid unless*

otherwise terminated in writing.

Caregiver/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____