Dear Friend,

Thank you for your interest in Longview’s Social Adult Day Program! We are happy to provide you with information about our program and the admission process.

Our Day Program is open from 9:00am-3:00pm, Monday through Friday. The daily rate is $55.00, which includes lunch and snacks, as well as a stimulating social and recreational program! Longview does not provide transportation to the program, however, you can arrange with Gadabout to provide this service for a nominal fee. The first step in our admission process is scheduling a visit for the day (no fee). We recommend a full day visit, which allows you to experience the program and get acquainted with staff and participants. If you decide to apply for admission to the Day Program following your visit, we require completion of our Admission Packet. This packet includes several forms and a medical evaluation, completed and signed by your doctor. The doctor’s evaluation must be based on an exam within 30 days of admission into the program. Thereafter, we require medical updates at six month intervals while you are enrolled in the program. It is the participant’s responsibility to immediately notify the Adult Day Program of any medical changes to ensure a comprehensive medical profile. For your convenience, we have included an Admission Checklist and all forms required for enrollment.

If you have any questions or wish to schedule a visit, please contact Pamela Nardi, pnardi@ithaca.edu or Mary Whittaker, mwhittaker@ithaca.edu or call us at the Day Program Office, 607-375-6323.

We look forward to hearing from you soon!

Sincerely,

Pamela M. Pesoli Nardi and Mary Whittaker

Program Coordinators/Longview Social Adult Day Program
Longview Social Adult Day Program Activity Schedule

**MONDAY**
9:00 COFFEE AND CONVERSATION IN THE ADULT DAY ROOM
10:00 EXERCISE WITH BREE AND HEAD START CHILDREN IN THE AUDITORIUM
10:30 HANGMAN AND GUGGENHEIM IN THE ADULT DAY ROOM
11:30 LUNCH IN THE LONGVIEW DINING ROOM
12:30 WALKING WITH THE DAY PROGRAM
1:00 STORY HOUR IN THE ADULT DAY ROOM
2:00 CLAY CLASS IN THE CRAFT ROOM WITH LAURIE

**TUESDAY**
9:00 COFFEE AND CONVERSATION IN THE ADULT DAY ROOM
10:00 FUN WEIGHTS AND STRAPS IN THE AUDITORIUM
10:45 TRIVIA IN THE ADULT DAY ROOM
11:30 LUNCH IN THE LONGVIEW DINING ROOM
12:30 WALKING WITH THE DAY PROGRAM
1:00 TAI CHI WITH LAURIE IN THE AUDITORIUM
2:00 CRAFTS WITH CHERYL IN THE CRAFT ROOM

**WEDNESDAY**
9:00 COFFEE AND CONVERSATION IN THE ADULT DAY ROOM
10:00 FUN WEIGHTS AND STRAPS IN THE AUDITORIUM
10:30 BOWLING IN THE AUDITORIUM
11:30 LUNCH IN THE LONGVIEW DINING ROOM
12:30 WALKING WITH THE DAY PROGRAM
1:00 WORD SEARCH IN THE ADULT DAY ROOM
2:00 CRAFTS WITH LAURIE IN THE CRAFT ROOM

**THURSDAY**
9:00 COFFEE AND CONVERSATION IN THE ADULT DAY ROOM
10:00 FUN WEIGHTS AND STRAPS IN THE AUDITORIUM
10:45 GAMES IN THE ADULT DAY ROOM
11:30 LUNCH IN THE LONGVIEW DINING ROOM
12:30 WALKING WITH THE DAY PROGRAM
1:00 CRAFTS IN THE ADULT DAY ROOM
2:00 BINGO IN THE AUDITORIUM

**FRIDAY**
9:00 COFFEE AND CONVERSATION IN THE ADULT DAY ROOM
10:00 EXERCISE WITH BREE AND HEAD START CHILDREN IN THE AUDITORIUM
10:30 MOSAIC CREATIONS IN THE ADULT DAY ROOM
11:30 LUNCH IN THE LONGVIEW DINING ROOM
12:30 WALKING WITH THE DAY PROGRAM
1:00 BAKING CLUB WITH LAURIE IN THE 4th FLOOR KITCHEN
2:00 GAMES IN THE ADULT DAY ROOM

ADP 2/17
Longview Social Adult Day Program

Admission Checklist

The items listed below are required for admission to Longview’s Social Adult Day Program:

➢ Schedule a visit by calling the Day Program, 607-375-6323

For participant review & files:

• Welcome Letter
• Statement of Participant’s Rights
• Activity Schedule
• Admission Criteria
• Operating Policies

Admission documents for participant to complete & return to the Adult Day Program Coordinator:

• Pre-Enrollment Application
• New Participant Form
• Pre-Admission Medical Evaluation
• Medical Care Plan
• Physician’s Approval to Administer Medication Form (if applicable-form provided upon request)
• Functional Assessment Form
• Emergency Contact Information
• Medical Emergency Authorization Form
• Admission Agreement
• Automatic Transfer Authorization Agreement (optional-form provided upon request)
• Image Release Form (optional)

Note: An admission meeting will be scheduled with the Adult Day Program Coordinator for final review & submission of required documents prior to official enrollment.

ADP 2/17
Longview Social Adult Day Program

Admission Criteria

- Must be fifty-five (55) years of age or older.
- Must indicate a willingness to participate in the program.
- Must be functionally challenged, whether due to physical or cognitive conditions.
- Must be capable of benefiting from socialization.
- Must not require constant one-on-one staff supervision because of functional or cognitive impairment as defined by standards for social adult day programs.
- Must be ambulatory either with or without the assistance of a wheelchair, cane or walker.
- Must not present a danger to oneself or participants.
- Must be capable of performing activities of daily living without skilled assistance.
- Family members and/or primary caregivers, if such exists, must be willing to assist client in participating in the program, including periodic meetings with staff to review participant’s individual care plan when needed.
- Must be capable of being transported to site.
- Applicant will be admitted only after an assessment by the Adult Day Program Coordinators.
Longview Social Adult Day Program

Pre-Enrollment Application

Applicant’s Full Name: ____________________________________________

Birth Date: ____ / ____ /____

Address: ___________________________ Phone: ______________________

_______________________________ SS#: ______________________

_______________________________ Sex: _____

Reasons for Applying for Social Adult Day Program:

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

Marital Status: ____  Present Living Arrangements: ___________________

Nearest Responsible Relative: __________________________

Address: ___________________________ Relationship: ________________

_______________________________ Daytime Phone: _____________

_________________________________________________________________

Physician’s Name: ________________

Limited on Activities: ____________________________________________
Statement of Purpose:
The Adult Day Community is to provide an environment that promotes social, physical, and cognitive stimulation. Through this stimulation we strive to improve the quality of life for adults over the age of fifty-five while providing respite care for their caregivers. The Adult Day Community brings adults from Ithaca and the surrounding areas to Longview for the day. They are welcomed participants in the Longview Community.

Name: ________________________________
Address: __________________________
____________________________________
____________________________________
Date of Birth: _____/____/_____
Sex: ______
Exam Date: ___/___/_____

Section 1: Medical History

<table>
<thead>
<tr>
<th>Primary Diagnosis:</th>
<th>Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent Surgery (Type of procedure and date):</td>
<td>Blood Pressure:</td>
</tr>
<tr>
<td>Recent Acute Illness (Type and date):</td>
<td>Activity Restrictions:</td>
</tr>
<tr>
<td>Chronic Illness, Physical or Mental Limitations:</td>
<td>Weight Bearing (Full, partial, none):</td>
</tr>
<tr>
<td>Allergies/ Special Diet:</td>
<td>Required periodic intermittent nursing care, and/or medical examinations, doctor’s visits, or skilled observation of symptoms:</td>
</tr>
</tbody>
</table>

Section II: Medications Needed (Type, frequency, and dosage):
____________________________________________________________________________
____________________________________________________________________________
__________________________________________________________

Section III: Observations of the Individual (circle Yes or No)

Yes / No :Individual capable of self-administration of required medication]
Yes / No :Ambulatory - without assistance
Yes / No :Ambulatory - with assistance
Yes / No :Chairfast – unable to transfer
Yes / No :Chairfast – able to transfer
Yes / No :Bedfast – unable to transfer
Yes / No :Bedfast – able to transfer
Yes / No :Incontinent (Describe)
Yes / No :Habituated or addicted to alcohol or another substance
Yes / No :If yes, is the individual a danger to his/herself or others?
Yes / No :Free of communicable disease

Section IV: Evaluation

In your opinion, do you feel this individual could benefit from adult social day care? Yes/ No

Section V: Tuberculin Test (Required within 30 days prior to admission unless medically contraindicated) __ Test is contraindicated

____ TST1: ______Date placed ______Date read ______mm
____ TST2: ______Date placed ______Date read ______mm
____ QuantiFERON-TB(QFT) ______Date placed_______Date read ______mm

Physician’s Signature: ______________________________   Date: __________
Please Print Name: _________________________________   Phone #:____________
Longview Social Adult Day Program

New Participant Form

Participant’s Full Name: ___________________________________________________

Begin Date: _____ / _____ / _____

Day(s) of Week Attending: ___ M ___ T ___ W ___ TH ___ F

Method of Transportation: _______________________________________________

Send Monthly Bill To:

Name: _________________________________________________________________

Address: _______________________________________________________________

______________________________________________________________

Daytime Phone: __________________________

Evening Phone: _________________________

Relationship to Participant: _____________

Program Coordinator’s Signature: ________________________________________
Longview Social Adult Day Program
Functional Assessment Form

Participant Profile

Name _____________________________      Phone _________________
Address ___________________________      D.O.B. ______________
                                             Sex       _____
                                             Race     ___________________
Religious Preference ____________      Living Arrangements _____________
Marital Status _________________      _____________

Family Members at Home:
Name:                                     Relationship:
    ____________________________    _________________________
    ____________________________    _________________________
    ____________________________    _________________________

Past Work Experience:
________________________________________________________________________
________________________________________________________________________

Educational Background: ________________________________________
Special Skills/ Interests:
________________________________________________________________________
________________________________________________________________________

Social Resources/ Needs

Family members with whom participant has supportive relationship:
________________________________________________________________________

Family members living nearby: ______________________________

Frequency of contacts: By phone_______      Visits to participant _________
Participants makes visits __________

Neighbors/ Friends who are supportive:
________________________________________________________________________
________________________________________________________________________

Social/ Conversational skills:
Initiates/ engages in conversation: ____________________________________________

Maintains social contacts: Neighbors ________ Church ________
Friends ________ Other ________________

Seeks needed help or assistance:
Assistance requested: _____________________ From: ________________________

Has someone to confide in (Name): ____________________________________________

Has someone who will provide necessary help in event of sickness (Name)
________________________________________________________________________

Has meaningful role in family ________________ Neighbor ________________
Social group ________________ Church ________________
Other _____________________________________________________

Social support system appears: ____ Very Supportive
____ Adequate
____ Inadequate
____ No social support system

Interviewer’s comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Social needs:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Physical Resources/ Needs

Ambulation: Walks without assistance: _____________________

Needs help with: ____ Stairs ________ ____ Carpeted floors
____ Uneven terrain
Walks with assistance of:

- Tripod
- Cane
- Wheelchair
- Walker
- Support of another person

Any paralysis: ____________________ What part of body: ____________________

Any difficulty with motor control: ________________________________________

Any sensory loss: ___________ Describe: _____________________________________

Any speech impediment/ aphasia: __________________________________________

Any loss of bowel/ kidney control: __________________________________________

Condition of teeth and gums: _____________________________________________

Weight problem: ____________ Evidence of malnutrition: _________________

Therapeutic diet: _________________________________________________________

Acute health problems: ___________________________________________________

Chronic health problems: ________________________________________________

Prescribed medications: For:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Non-prescription drugs: For:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Can take own medication: ___________ Needs supervision: ________________

Medications must be administered: ________________________________________

Any history of alcoholism: ________________________________________________

Other substance addiction: _______________________________________________

Days of illness during last six months (unable to carry out normal activities):

Number of days spent in hospital/nursing home/rest home in last six months:  

Page 3 of 6
Able to participate in physical activities:  
- Walking  
- Swimming  
- Exercise sessions  
- Outside games  

Any prescribed therapy or activity: ___________________________________________

Any supportive devices being used:

- Leg brace  
- Artificial limb  
- Hearing aid  
- Glasses  
- Contact lenses  
- Dentures  
- Catheter  
- Kidney dialysis  
- Colostomy equipment  

Other: ____________________________________________________________

Any special instructions/ assistance needed with these: __________________________

Interviewer’s comments:
________________________________________________________________________
________________________________________________________________________

Needs not presently being met:
________________________________________________________________________

Mental/ Emotional Resources and Needs

Any diagnosed mental/ emotional illness or problem:
________________________________________________________________________
________________________________________________________________________

Any observed indications/symptoms of mental/emotional disorders:

- Depression  
- Anxiety  
- Withdrawal  
- Paranoia  
- Hypochondria  
- Confusion  
- Disorientation  
- Memory loss  
- Sense of uselessness  
- Hallucinations  
- Acting out  
- Aggressive behavior  
- Sexual fixation  
- Hostility  
- Self-neglect/ abuse  
- Anger  
- Wandering  
- Other  

Describe symptoms:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Able to express self verbally: _________ Exhibits understanding of others: _________

Appears able to make decisions: _________
Exhibits evidence of: _____ Independence _____ Dependence
Describe: __________________________________________________________

Evidence of self-motivation: _______________________________________
Appears to maintain healthy relationships: __________________________
Copes well with others: ___________________________________________
Manages personal affairs: ______ Another person manages affairs: ______
Shows common sense in making judgements: ________________________
Exhibits ability to adapt to new circumstances and situations: __________
Demonstrates ability to adjust to any loss of function/ change in roles: ______
Finds use for leisure time: _____ List activities: ________________________

Interviewer’s comments:
_________________________________________________________________
_________________________________________________________________

Needs not presently being met:
_________________________________________________________________
_________________________________________________________________

ADL/IADL Resources and Needs
Cares for personal grooming: _____ Well
_____________________ Adequately
_____________________ Inadequately
_____________________ Has help (Describe: _________________________)
_____________________ Grooming not cared for
Is able to care for personal needs (Insert code below: 1= Without assistance, 2= Supervision is needed, 3= Assistance of equipment, 4= Assistance of a person, 5= Assistance of equipment and a person, 6= Unable to accomplish, 7= not observed):

<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eating</td>
<td></td>
<td></td>
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<tr>
<td>2. Meal preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Toileting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Dressing/Undressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Bathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Getting in and out of bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Household chores</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Shopping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Laundry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Manages finances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Manages household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Takes own medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Uses public transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Uses telephone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature ________________________________ Date: ___________

Position: _________________________________
Longview Social Adult Day Program

Emergency Contact Information

Full Name: ____________________________

Birth Date: ____ / ____ /____

Address: ____________________________ Age: ______

______________________________ SS#: ____________________________

______________________________ Phone: ____________________________

Physician’s Name: ________________ Phone: ____________________________

Nearest Responsible Relative or Friend:

Name: ____________________________

Address: ____________________________ Home Phone: __________________

______________________________ Work Phone: __________________

Two Persons who can be contacted in addition to above:

Name: ____________________________

Address: ____________________________ Home Phone: __________________

______________________________ Work Phone: __________________

Name: ____________________________

Address: ____________________________ Home Phone: __________________

______________________________ Work Phone: __________________
Longview Social Adult Day Program

Medical Emergency Authorization Form

I hereby authorize the Longview Social Adult Day Program Director or designee to obtain the necessary health care service and transportation for me in the event of a medical emergency while I am a participant in the program.

The cost of these medical services is the responsibility of the participant.

Signature of Participant: ____________________________________________

Signature of Family Member or Representative: __________________________
Longview Social Adult Day Program

Admission Agreement

I, __________________________ enter into agreement with Longview’s Social Adult Day Program with the following stipulations.

1. I agree to abide by the rules and regulations of Longview as they apply to the program.

2. The program operates between 9:00am-3:00pm, Monday through Friday (with the exception of announced holidays) with the family or representative assuming care at other times.

3. Services provided by the program include:
   a. Nutritious noon meal
   b. AM and PM snacks
   c. Supervision
   d. Leisure time activities (see Activity Schedule)
   e. Comfortable chairs provided for rest if needed

4. Transportation is the responsibility of the participant and/or family or representative.

5. Participation in the program is dependent upon the participant’s level of care and supervisory needs. The grounds on which involuntary termination may occur are:
   a. Staff evaluation determines the participant requires a higher level of care;
   b. The participant manifests behaviors which cannot be adequately or appropriately managed in the program setting;
   c. Non-payment of program fees.

6. I release Longview from any liability for injury and damages due to my own negligence.
7. I agree to provide the program with information concerning the participant’s health status and any changes, as they may occur.

8. Prior to admission to the program, the participant must obtain and provide a written, dated and signed statement from the participant’s physician. Changes in the participant’s medication(s) will be shared with the program staff. I voluntarily agree not to attend the program if I am feeling ill or have a contagious disease. The program may require information from the participant’s physician before the participant returns to the program.

9. The cost of the day program is $55.00 per day, which includes lunch and snacks. Billing is at the beginning of the month for the days you have reserved. Payment is due by the 7th day of the month. Longview may collect a late fee of $5.00 as of the 8th and $1.00 for each additional day the fee remains unpaid. If 30 days late, notice of suspension from the program will be issued. After 45 days participant’s slot cannot be guaranteed. Credits will be given when a participant is absent and can provide a doctor’s note or notice of a hospital stay. Participants will not be billed for the days the program is closed for holidays or other reasons such as weather conditions.

10. The participant and/or the undersigned (responsible party of the participant) acknowledge that they have been fully informed of the participant’s rights, and also acknowledge that they have read and understood this agreement and have received a copy thereof.

____________________________________ __________________
Participant       Date

____________________________________ __________________
Responsible Party      Date

____________________________________ __________________
Program Coordinator      Date

State and federal laws prohibit discrimination based on race, creed, color, national origin, sex, handicap, or source of payment.
Longview Social Adult Day Program
Medical Care Plan

Name: ___________________________  Age: _____   ADM. Date: ___ /___/___   Physician: ________________

Medications:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Allergies:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Treatments:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
Longview Social Adult Day Program
Statement of Participant’s Rights

The Longview Social Adult Day Community Program shall uphold the basic human rights and civil rights of the participants involved in the center’s programs. These rights shall be safeguarded and respected.

1. The right to be treated as an adult with respect and dignity.

2. The right to participate in a program of services and activities that promote positive attitudes on one’s usefulness and capabilities.

3. The right to participate in a program of services designed to encourage learning, growth and awareness of constructive ways to develop one’s interests and talents.

4. The right to be encouraged and supported in maintaining one’s independence to the extent that conditions and circumstances permit, and to be involved in a program of services designed to promote personal independence.

5. The right to self-determination within the day community setting, including the opportunity to:
   a. Participate in developing one’s plan for services.
   b. Decide whether or not to participate in any given activity.
   c. Be involved to the extent possible in program planning and operation.

6. The right to be cared about in an atmosphere of sincere interest and concern in which needed support and services are provided.

7. The right to privacy and confidentiality.

8. The right to know the cost of the program.
Inclement Weather Closing & Notification Procedure
When it becomes necessary to close the Longview Social Adult Day Program due to inclement weather, the following procedures will be followed: Closing for the Day – Adult Day Program (ADP) staff will notify (via telephone) each participant/family of the closing. All participants will be notified by 7:00a.m. ADP Staff will also notify Gadabout of the closure. Early Dismissal – In the case of early dismissal/closure, which is rare, the ADP staff will contact family members by telephone to arrange an earlier pick-up time. Staff will also notify Gadabout of the early dismissal/closure. ADP Staff will remain on site until all participants have been picked up. School Closings – The day program will not automatically close when the area schools close. Although road closings will always mean an automatic program closure, our decision to close at other times will be based on what we determine to be very hazardous driving conditions and concern for safety. Program Fees – There will be no fees billed for inclement weather closings.

Six Month Medical Evaluation
All clients are responsible for obtaining (every six months) a medical update from their physician (a PPD will not be required with the update). A six month medical form is provided by the day program and will be mailed to the client one month prior to the due date. The six month medical update is required to continue in the program without interruption.

Participant Transportation
All arrangements for transportation to and from the adult day program is the sole responsibility of the participants and their families. Family members must escort the participant to the adult day program room to ensure a safe arrival. The day program must have on file the name(s) and contact information of all drivers. Please include any drivers that might be needed for last minute changes. Program pick-ups must occur no later than 3:00pm. Repeated late pickups will result in a verbal warning and possible dismissal from the program.

Participant Absence
Please contact the Day Program Office, 607-375-6323, if you are going to be absent from the program. Credits will be given when a participant is absent and can provide a doctor’s note or notice of a hospital stay.
Payment Schedule
Payment is due on the 7\textsuperscript{th} of the month. Nonpayment by the 30\textsuperscript{th} will result in suspension from the program until the outstanding balance is paid in full. After 45 days your slot cannot be guaranteed.

Gifting Policy
Longview observes a no gifting policy for all employees. Employees may not accept gifts in any form, monitory or other, from any resident or client of Longview. There are no exceptions to this rule.

ADP 12/17