Meals On Wheels Atlanta
The Vivian T. Minor Adult Day Health Center

Date of Provider Contact: _____

I,_____ request the following services from ADH: _____

_____

___ I understand the range of services offered to me and agree to accept the following specific services:

- ☐ Daily medical monitoring by a RN/LPN including medication administration.
- ☐ Medical oversight by RN, including Care Planning and Therapeutic activity oversight.
- ☐ Nutritious meals that meet the 1/3 RDA and comply with any special dietary restrictions.
- ☐ Therapeutic activities from which I can choose to participate.
- ☐ Personal care services as needed with the exception of nail cutting or foot care.
- ☐ Staff supervision and oversight to ensure safety and security.
- ☐ Adherence to the emergency procedures that I have pre-instructed. The center RN or LPN will make the decision to initiate a client's emergency illness plan.
- ☐ Social Service information and referral as needed and requested.

___ I have received a copy of the Bill of Rights and Responsibilities. I understand my responsibilities as a service recipient and will comply. In addition, I have been informed on the protocol for filling a complaint or grievance.

___ I understand that upon the start of services within at Meals on Wheels Atlanta, I will receive the complaint procedures within ten calendar days of the start date. Participants and families have the right to report concerns/complaints to MOWA. Established to enable participants and their families or representatives, if any, to have their concerns addressed without fear of reprisal.

___ I understand the Center's participant confidentiality policy and procedure. I understand that all employees and volunteers are bound by these policies and I in turn will protect the confidentiality of my fellow participants.

___ I understand the Center's policy as it relates to the trial period, not to exceed 7 days, but this trial period gives potential participants and caregivers a chance to interact with staff and other participants and to see what our center offers. This also allows both parties the opportunity to conduct a needs assessment and compare that with the center's capabilities.

___ I, **do/do not** (circle one) give my permission to have photographs/videos taken of me in my home, at the Meals on Wheels Atlanta, and/or at any program or activity sponsored by the agency. I understand and approve the use of these photographs/videos for the purposes of showing services given by the MOWA. I understand and approve the use of these photographs/videos to publish in print and/or electronically. This could include publications such as newspapers, press releases, internet web page, social media outlets and/or newsletters. The MOWA may publish materials, use my name, photograph/video, and/or make reference to me in any manner that the agency deems appropriate in order to promote and publicize services. I understand that one photograph will be taken for security reasons. This photo will be in my client record only and not released to the public. Rev. 4/10

___ I, _____ , request that I be allowed to participate in field trips and activities sponsored by the Meals on Wheels Atlanta, I understand that my participation is voluntary. I release the MOWA from any and all responsibility for any injury or illness resulting from my participation in activities and field trips.

___ I have provided information for emergency procedures and understand that staff will follow these procedures in the event of an emergency.

___ I have been advised of my rights to specify my wishes through Advance Directives and have received information on where to obtain assistance with a Living Will or Durable Power of Attorney.

___ I understand the Center's admission, discharge, and transfer criteria and have had any questions regarding these issues answered to my satisfaction.

___I agree to immediately arrange for pick-up from the Center if a participant is contagious, becomes ill or behaviors exceed the staffing acuity. If pick-up does not occur within 1 hour, the participant's emergency illness plan will be initiated.

___ I understand the Center's overpayment policy and have received information concerning how refunds will be handled.

___ I have received the holiday closing schedule of the Meals on Wheels Atlanta. Participants may refer to the local radio and television stations for information regarding the unscheduled closing of the Center due to disaster or severe weather. The broadcast will inform both of closing and/or adjustment in operating schedule. In addition, the participant can also call the main office number to receive a recorded message.

___ I understand that in the event of a facility or community disaster that requires immediate and/or permanent evacuation of the Center, I will be required to immediately pick-up the participant. If pick-up doesn't occur within two hours, participants will be relocated to the main offices of MOWA or to the closest designated shelter as established by the local Public Health Department or Red Cross. Information about the location of this shelter can be obtained via radio, television of by recorded message at MOWA main offices.

___ I reserve the right to refuse to drink milk during the breakfast and lunch meals that MOWA serves to me.

I, _____have agreed to have MOWA Provide the services indicated below.

Services	**Days of services per week**	**Number of weeks**	**No. of Units of weeks**	**Unit Cost**	**Cost per Month**
Adult Day Health				**Level 1: $50.45/day Level 2: $63.07/day**	
Adult Day Care (Social)				**$60.00 day**	
Drop-In ADH				**$10.00/hr**	
Transportation				**$10.00/trip**	

Meals On Wheels Atlanta
The Vivian T. Minor
Adult Day Health Center

Circle days of attendance: M Tu W Th F

Time of attendance: _____ - _____

____ I agree to attend the Center on the specified days indicated.

a. Estimated fee for one month $_____

b. Estimated monthly cost share (MAO only) $_____

c. Cost share $_____ per visit

d. The cost will be covered by:

___ Alzheimer's Grant ___ CBS-Ind ___ CBS-M ___ CCSP

___ Source ___ CBS-CG ___ Title111E ___ Private Pay

___ I understand that the hours of operation: 8:00am to 5:00pm Monday through Friday.

___ I understand that late pick up policy includes the following:

- Participants not picked up by the designated time of closing, will be charged a fee. Any participant picked up after closing time is considered a late pick-up and therefore charged a **$1.00 per minute** late fee. An additional dollar for each minute will be charged while the participant is at the Center under staff care.

- Payments must be made in full when the participant is picked up from the Center or before the participant returns to the Center. Services will be denied until full payment is received.

- If for any reason a caregiver is delayed or running late, they must call the Center at least 30 minutes before closing. If the participant's family can not be contacted by 30 minutes after closing the Center, the participant will be taken to the County Police or Sherriff's Department for safe keeping until family can arrive.

If you are not going to attend ADH on any given date, you must cancel transportation by 7:30 a.m. to prevent the employee from arriving at your residence. You will be charged for full service if prior notice of cancellation is not received.

___ I understand the above daily cost for services does not include the following:

- Any contracted direct services received by a 3rd party (i.e. transportation, beautian, physical, speech or occupational therapy)
- Personal hygiene items, (i.e. adult briefs, change of clothes)
- Medical or supplement supplies (i.e. , bandages, medications, Ensure medical equipment, restraints)

___ I understand that if I received a subcontracted service while at the Center, that I will receive a bill directly from 3rd party provider. It is my responsibility to resolve any and all billing issues directly with that provider. I understand that MOWA does not in any way provide information or become involved with billing issues between you and a 3rd party payor.

If you pay full fee or have a cost share, you will be billed monthly for all services you have received during the month. The bill is due once you receive the invoice, and services may be stopped if payments is not received within 30 days of the billing date. Payments may be mailed or hand delivered to staff. Private pay participants with a signed participant agreement who have an overdue bill that has been outstanding for thirty (30) days and have not made payment arrangements with the billing office to pay for services that have been rendered, will be terminated within 10 days written notification. You have the right to cancel this participant agreement at any time and shall only be charged for services you have actually received prior to the time SCS is notified of the cancellation.

Name: _____

Address: _____

_____

City State zip

Phone: _____

_____ _____

Signature of Participant/Representative Date

_____ _____

MOWA Staff Date