Hope Alzheimer's Center

ENROLLMENT APPLICATION

25 Brayton Avenue
Cranston, Rhode Island 02920
(401) 946-9220 Fax (401) 946-3850

Ellen Grizzetti – President & CEO

2022

*Hope Alzheimer's Center is licensed by the Rhode Island Department of Health

WHAT IS HOPE ALZHEIMER'S CENTER?

Hope Alzheimer's Center is a comfortable, safe and homelike day center staffed by caring and skilled individuals who provide comprehensive health, personal care, social and therapeutic services.

WHAT IS THE MISSION OF THE HOPE ALZHEIMER'S CENTER?

To be a leader in fulfilling the unique needs of the individual with dementia and supporting their caregivers, while optimizing each person's independence and dignity.

We will accomplish this by…
Providing quality and compassionate services in a safe and caring environment
Focusing on the individual's abilities and strengths while being sensitive to limitations
Providing therapeutic activities that enhance self-esteem
Providing a socially and medially supervised environment
Encouraging independence and success
Providing education, emotional support and personal counseling
Providing educational lectures and workshops for the caregiver to enhance a therapeutic environment at home
Recruiting and retaining a quality staff
Sharing our expertise with health care professionals and the community

WHO IS ELIGIBLE TO ATTEND?

- Individuals who have a medically confirmed memory loss resulting from Alzheimer's disease or related dementia
- Individuals who would benefit from structured, meaningful activities which encourage social stimulation and preserve self-esteem
- Individuals who have a need for ongoing health monitoring, supervision with nutrition and medication, or assistance with personal care
- The Center will not discriminate in serving any person on any legally recognized basis, including but not limited to race, color, religion, sex, marital status, pregnancy, physical or mental disability, age national origin, sexual orientation, ancestry or veteran status.

HOURS OF OPERATION AND NONDISCRIMINATION POLICY

- Hope Alzheimer's Center is open Monday through Friday from 8:00 a.m. – 4:00 p.m.
- The Center will not discrimination in serving any person on any legally recognized basis, including but not limited to race, color, religion, sex, marital status, pregnancy, physical or mental disability, age, national origin, sexual orientation, ancestry or veteran status.

HOW TO ENROLL IN THE HOPE ALZHEIMER'S CENTER PROGRAM

- If you have questions or concerns or to arrange a tour, feel free to contact Hope Alzheimer's Center at 946-9220 and ask to speak with a case manager.
- Return completed forms to:
  Hope Alzheimer's Center
  25 Brayton Ave.
  Cranston, RI 02920

SERVICES PROVIDED BY HOPE ALZHEIMER'S CENTER

Program Activities:
A full range of daily social and therapeutic activities includes, but is not limited to the following:

*Watercolor program
*Current events
*Reminiscence
*Arts & crafts
*Pottery program
*Woodworking
*Participants council
*Community service projects
*Dance & movement therapy
*Horticultural therapy
*Cognitive Fitness
*Chair tap dancing
*Intergenerational programs
*Clay sculpting
*Poetry club
*Music programs
*Exercise and yoga
*Pet therapy
*Mental stimulation activities
*Arts & crafts
*Cooking
*Men's club
*Entertainment

Nutrition:
- Two meals and a snack provided
- Cueing and feeding assistance as needed

Personal Care:
- Showers (provided by certified nursing assistants)
- In- house hairdressing services, including wash, cut, styling, perms, coloring, etc.
- Toileting assistance
- Nail care

Health Care:

Skilled nursing services provided by registered nurses
- Monthly health assessments; weight, BP, respiration and pulse
- Multidisciplinary care planning
- Medical follow-up and care coordination with physicians
- Nutritional supervision and management of special diets
- PT, OT and Speech therapy services provided on site in partnership with Saint Elizabeth Homecare Services

Care may also include:
- Dispensing of medication
- Dressing changes
- Injections
- Lab specimen collection
- Podiatry services provided by a visiting podiatrist
- Occupational, speech and physical therapy (arranged on a contractual basis)
- Health assessments
- Care planning assistance and family support

Social Services/Care Management
- Client assessment
- Care coordination
  - In home service
  - Respite care
  - Hospice care
- Support groups
- Transportation services- may be arranged, on specially equipped vans on a space-available basis
- Guidance in determining eligibility for and in accessing financial assistance programs
- Assistance with long term care planning
- Educational programs for caregivers

Application for Enrollment
Hope Alzheimer's Center, 25 Brayton Avenue, Cranston, RI 02920
401-946-9220 401-946-3850 Fax

(To Be Completed by Caregiver)

Applicant's Name:_____ **Phone:**_____

Address:_____ **City:**_____ **Zip:**_____

Date of Birth:_____ **Social Security Number:**_____

Medicare:_____ **Medicaid:**_____

Other Health Insurance:_____ **Number:**_____

Medical History:_____

_____

_____

Caregiver's Name:_____

Address:_____

Home Phone:_____ **Work Phone:**_____ **Email:**_____

Primary Care Physician:
Name:_____ **Phone:**_____

Address:_____ **City:**_____ **Zip:**_____

Specialists or additional physician contacts:
Name:_____ **Phone:**_____

Address:_____ **City:**_____ **Zip:**_____

Name:_____ **Phone:**_____

Address:_____ **City:**_____ **Zip:**_____

Does potential participant require a special diet? _____Yes _____ No
If "Yes" please explain:_____

_____

Does potential participant take medication on a daily basis? _____ Yes _____ No
If "Yes" please list:_____

_____

Is potential participant incontinent of bladder or bowel? _____ Yes _____ No
If "Yes" please explain:_____

_____

Does potential participant require assistance with ambulating? _____ Yes _____ No
If "Yes" please explain: Walker? Wheelchair? Cane? _____

_____

Application for Enrollment (continued)
Hope Alzheimer's Center, 25 Brayton Avenue, Cranston, RI 02920
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How many days of attendance are requested?_____
Which days are preferred?_____
Is transportation needed?_____

Please list any concerns or comments regarding applicant's physical health and/or emotional well-being:

_____
_____
_____

Hope Alzheimer's Center Daily Fee **$89.00**

Hope Alzheimer's Center ½ day fee **$69.00**
*A half day is defined at four (4) hours of care, and is limited to either **9 a.m. to 1 p.m. or 12 p.m. to 4 p.m.**

***Case Managers will work with family caregivers to secure State subsidies for those who are eligible**

Please find the Rhode Island Office of Healthy Aging 2022 Guidelines for the Cost-Share Program

1. Income of **$16,988** (Single); **$22,888** (Couple) - **$7.00**/day
2. Income of **$27,180** (Single); **$36,620** (Couple) - **$15.00**/day
3. Income of **$33,975** (Single); **$45,775** (Couple) - **$15.00**/day

If you would like us to help determine your potential eligibility for subsidy programs please list the financial information of the **participant and spouse** combined:

Income	**Annual**
Social Security	**$**_____
Rental Property	**$**_____
Interest/Dividends	**$**_____
All Pensions	**$**_____
Total	**$**_____

_____ _____
Applicant's Signature Date

_____ _____
Legal Guardian/Power of Attorney Signature Date

Hope Alzheimer's Center
Social History

Client Name:_____ Likes to be called:_____

Gender:_____ D.O.B.:_____ Place of Birth_____

Ethnic Background:_____ Primary Language:_____

Secondary Language:_____

Religion:_____ Holidays Observed:_____

Diagnosis (es):_____

Diet Restriction/Intolerances:_____

Marital Status:_____ Name of Spouse:_____ Years Married:____

Lives with:_____

Number of siblings:_____ Names most often remembered:_____

Number of children:_____ Names most often remembered:_____

Number of grandchildren:_____ Names most often remembered:_____

Educational history:_____

Occupational history:_____

Military history:_____

Interests: PLEASE CHECK APPROPRIATE LINES
Music:_____ Singing:_____ Dancing:_____ Movement Therapy:_____ Sports:_____

Painting:_____ Drawing:_____ Crafts:_____ Baking:_____ Spiritual Activities:_____

Exercise:_____ Walks_____ Gardening:_____ Reading:_____ Pet Therapy:_____

Checkers:_____ Chess:_____ Bingo:_____ Cards/What games?:_____ Reminiscence:_____

Additional Interests & Hobbies:_____

_____

_____

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Medical Form

(to be completed by the participant's physician)

Patient's Name:_____ D.O.B._____

Address_____ City_____ Zip_____

Past & Present Diagnosis (Please check or list as appropriate)
Dementia diagnosis: □ Alzheimer's □ Vascular □ Mixed □ Other_____
□ CAD □ CHF □ CVD □ HTN □ AFIB □ PVD □ DM
□ Thyroid disorder □ Depression □ Cancer (details)_____
Other:_____

***Please check the following medications that may be given on a PRN basis:**
□ Tylenol □ Ibuprofen □ Maalox □ Tums

Food or Medication Allergies or intolerances? □ Yes □ No
Special dietary requirements_____

To the best of my knowledge participant

Immunizations	**Date**
Pneumococcal	_____
Influenza	_____
Tetanus	_____
COVID-19 Vaccine	_____

Summary of Last Physical Exam/Vitals **Date of Last Exam:** _____

Blood Pressure_____ **AP**_____ **Respiration**_____
Height_____**Weight**_____**Lungs**_____**Other**_____

Functional Status
Does the patient ambulate independently? □ **Yes** □ **No**
If not, nature of assistance required:_____
Other limitations on activities_____

Physical, Occupational, Speech Therapy

There is no contraindication for my patient to receive ☐ **Physical**, ☐ **Occupational** or ☐ **Speech** therapy by licensed therapists, providing group or individual treatment at the Hope Alzheimer Center. I consent to the receipt of these services. ☐ **Yes** ☐ **No**

Current Medications and Dosage:_____

Physician:_____ Phone_____ Fax_____
Address_____ City_____ State_____ Zip_____
Hospital of Choice_____ Physicians' Signature_____ Date_____
*Family wishes may supersede Physician's Choice

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MEDICAL RECORDS RELEASE

I hereby request that any medical/mental health date pertinent to

_____

Be released to the Hope Alzheimer's Center. Also, medical data pertinent to his/her well being may be released in an emergency situation at the discretion of the Hope Alzheimer's Center staff. The Hope Alzheimer's Center also has the right to release any pertinent medical data to the Department of Veterans Affairs.

APPLICANT'S SIGNATURE:_____

Or

LEGAL GUARDIAN/POWER OF ATTORNEY:_____

WITNESS:_____

DATE:_____

Or

I have read and understand the Medical Records Release and choose not to sign it. I further understand that my choice not to sign may result in the discontinuation of enrollment.

LEGAL GUARDIAN/POWER OF ATTORNEY:_____

WITNESS:_____

DATE:_____