Our Place Respite

Participant Packet

Caring for Caregivers. Honoring Friends.

We are so excited for your loved one to be joining our Our Place Respite community! Please know it is our intention to fill their days here with love, purpose, and fun!

Be sure to fill out the necessary forms included in this packet so that we have the information needed to best care for your loved one while they are at Our Place Respite.

Keep My Information Handy!

Jennifer Carlisle, Our Place Respite Program Director

Phone/Text: 334-866-8610

Email: ourplaceal@gmail.com

Facebook: facebook.com/Ourplaceal

Make sure to let me know if your loved one will not be attending on their regular day. Connect with Our Place Respite on Facebook to see how much fun we are having!

Our Place Respite

Form Checklist

To Complete Enrollment, Please:

- ➢ Review the Enrollment Packet and complete all forms on the checklist below.
- ➢ Submit completed forms with the $40 registration fee. Checks payable to Our Place Respite — note participant name in memo line.
- ➢ Submit a copy of insurance card and identification for the participant.
- ➢ Receive a copy of your signed forms from the Director. Retain for your records.
- ➢ Optional: Submit a copy of Living Will and/or DNR if applicable.

YOUR FORM CHECKLIST	COMPLETE
All About Me! Form	☐
New Participant Enrollment	☐
Policies and Procedures	☐
Medical Enrollment Form *Note: Portion to be completed by physician or office representative*	☐
Consent for Emergency Care	☐
Copy of Guest insurance card and identification	☐
History of Violence	☐
Photo, Media, Field Trip & Driving Release Form	☐
Liability Release	☐
Enrollment Contract	☐
I have submitted a copy of identification for Guest	☐
I have submitted a Living Will and/or DNR (optional)	☐
I have received a copy of forms for my records	☐

Our Place Respite

Participant Photo

Please attach or tape a recent photo of the participant below.

This helps our volunteers recognize and connect with your loved one.

ATTACH PHOTO HERE

Participant Name: _____

Preferred Name / Nickname: _____

Our Place Respite

All About Me!

Help us get to know your loved one! Please tell us all about them and include a recent picture to help our volunteers connect with them.

Participant Name (Nickname): _____

□ Married (# years ____) □ Widowed □ Divorced □ Single

Spouse Name: _____

Birthday: _____

Church Affiliation: _____

Children? Names: _____

Grandchildren? Names: _____

Siblings? Names: _____

Pets: _____

Military Service? Division: _____

Previous Profession: _____

Hobbies/Interests: _____

Favorite Music Genre/Songs: _____

Favorite Food: _____

Favorite Dessert: _____

Favorite Holiday(s): _____

Favorite Sport: _____

Prefer Hot or Cold: _____

Dominant Side: _____

Favorite Scent: _____

Favorite Color: _____

Room Preference: □ Dark □ Light

Taste Preference: □ Sour □ Sweet

Prefer people close or at a distance: _____

What do they like to touch? Soft or rough: _____

Stories they like to tell: _____

Is there anything else you'd like to share? (likes, dislikes, proud moments, unique facts):

_____

Other Info

Level and method of mobility / ways participant may need assistance:

Level of independence in eating / ways participant may need assistance:

Level of independence in toileting / ways participant may need assistance:

How participant functions in a group / ways he/she may need assistance:

How does participant display agitation, stress, or intense emotion?

What are triggers for agitation, stress, or intense emotion?

What proactive steps can Our Place Respite staff take to prevent or reduce agitation?

Emergency Contact Information

List TWO people (in addition to Care Partner) who can be reached in an emergency:

Name: Phone(s):

Name: Phone(s):

Participant's Physician: Phone:

Hospital of Choice:

Our Place Respite

New Participant Enrollment Form

Participant Name: _____ Birthdate (MM/DD/YYYY): _____

Care Partner Name: _____ Relationship: _____

Which day(s) will participant attend? □ Tuesday □ Thursday

Guest Marital Status: □ Married (# years ____) □ Widowed □ Divorced □ Single

Care Partner Phone(s) — include all numbers:

_____

Care Partner Address: _____

City & State: _____ Zip: _____

Care Partner Email: _____

Billing

Send invoice for Our Place Respite to:

□ Care Partner at address above

□ Different person/address (complete below)

Billing Name: _____ Relationship: _____

Billing Address: _____ Zip: _____

Billing Email: _____ Phone: _____

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ACH Payment Authorization

Payments are processed monthly by ACH (Automated Clearing House) bank transfer. Please provide your banking information below, or attach a voided or cancelled check.

Bank Name: _____

Account Holder Name: _____

Routing Number: _____

Account Number: _____

Account Type: □ Checking □ Savings

□ **I have attached a voided/cancelled check in lieu of providing account information above.**

By signing below, I authorize Our Place Respite to initiate ACH debit entries to the account listed above for monthly session fees.

Participant Name: _____

Date: _____

Guardian Signature: _____

Our Place Respite

Policies and Procedures

General Information

Our Place Respite is a faith-based ministry designed to meet the social, emotional, physical, and spiritual needs of adults with memory loss and their care partners, providing activities and socialization in a safe and caring setting.

Services Offered

For Friends:

A safe, loving environment with activities including group singing, crafts, community services, reminiscing, exercise, art, and socialization.

For Care Partners:

Respite during program hours, a bi-monthly caregiver support group, and information about community resources and care options.

Hours and Attendance Policy

Hours

- Our Place Respite operates Tuesdays and Thursdays, 10:30 AM – 2:30 PM. Closed on all legal holidays. Advanced notice of closings will be communicated to participants and caregivers.
- Drop-off is at 10:30 AM. Please, no early drop-offs.
- Pick-up is at 2:30 PM. Please, no late pick-ups.
- If local schools are closed for weather, Our Place Respite will also be closed.

Attendance Policy

Participants are expected to attend as scheduled. Food, supplies, and volunteers are prepared based on expected attendance. Please communicate all absences promptly.

To report an absence: Contact Jennifer Carlisle at 334-866-8610 (call or text) or ourplaceal@gmail.com by 9:00 AM.

- Caregivers must notify the director by 9:00 AM for any absence. A $40 fee will be charged for unnotified absences.

- Medical Appointments: Please schedule on non-Our Place Respite days when possible. 48-hour notice required otherwise.
- Illness: Keep participant home if ill. Must be fever-free for 24 hours before returning.
- Late Arrivals: Walk your loved one in — do not drop off at the door.
- Trips/Vacations: Minimum 48-hour notice for planned absences.
- No-Shows: Participants who do not attend without prior notification will be invoiced for that day.

Admission and Discharge

Admission Criteria

- Medical stability
- Ability to ambulate independently with or without assistive devices
- Ability to perform basic daily living activities independently
- Ability to interact and socialize with others
- Ability to exhibit acceptable behavior in a group

Possible Exclusions

- Unmanaged incontinence
- Disruptive or combative behavior
- Psychosis
- Communicable disease
- Need for one-on-one continual supervision

Transition and Discharge

Discharge plans are made when another level of care is needed. Our Place Respite staff will communicate openly with families and suggest options for ongoing care. Discharge decisions rest with the director.

Payment & Rates

Registration Fee: $40 (one-time, due upon enrollment)

Daily Fee: $40 per session

Payment: Billed monthly by ACH. Statements issued at end of month; payment due by the 15th.

Scholarships available for qualifying participants.

Communication

Open communication between caregivers and the director is essential. For concerns or suggestions, contact Jennifer Carlisle at 334-866-8610 or ourplaceal@gmail.com. Follow us on Facebook: facebook.com/Ourplaceal

Medication / Health / Injury

Our Place Respite does not administer medications. Participants must manage their own medications independently during program hours.

No staff member is a medical professional. Signs of illness will result in a call to the caregiver for pickup. Injuries will be reported and appropriate care arranged, including 911 if necessary.

I have read, understand, and agree to the Policies and Procedures of Our Place Respite Ministry:

Participant Name: _____ Date: _____

Guardian Signature: _____

Our Place Respite

Medical Enrollment Form

Participant Name: _____ Date of Birth: _____

Name of Doctor: _____ Preferred Hospital: _____

Insurance Company: _____ Name on Policy: _____

Policy Number: _____ Group Number: _____

NOTE: A copy of your insurance card will be requested. The section below is to be completed by a physician or office representative.

Current Disease/Chronic Condition	Yes	Special Attention Required	Activity Restriction
Dementia (type)			
Anemia			
Arthritis			
Asthma			
Cerebral Palsy			
Diabetes			
Effects of Stroke/Paralysis			
Emphysema/Bronchitis			
Epilepsy/Seizures/Fainting Spells			
Gastrointestinal Problems			
Heart Trouble			
Autoimmune (please specify)			
High Blood Pressure			
Kidney/Urinary Tract Problems			
Parkinson's Disease			
Skin Disorders			
Tuberculosis			

Other diseases or conditions not listed: _____

Allergies (food, medicine, animals, environmental, other):

_____

Currently receiving medical treatment? □ No □ Yes — explain:

_____

Any known psychiatric problems? □ No □ Yes — comment on nature, severity, and treatment:

_____

_____

Medical restrictions on physical activity? □ No □ Yes — explain:

_____

Special diet required? □ No □ Yes — explain:

_____

Please list current medications including dosage and frequency:

Medication	Dosage	Frequency

MEDICAL INFORMATION COMPLETED BY (PRINT):

_____

SIGNATURE:

_____

DATE: _____ POSITION: _____

OFFICE NAME:

_____

Our Place Respite

Consent for Emergency Medical Care

Participant Name: _____

➢ I hereby give permission to staff (paid and volunteers) to provide direct emergency care for minor emergencies or to access 911 emergency medical services as deemed necessary.

➢ Any resultant bill will be the responsibility of the participant and/or caregiver/guardian, who will be responsible for filing all medical insurance claims.

➢ In the event of a non-emergency medical situation, staff may request a doctor see the participant. The participant cannot return without a report concerning the incident.

➢ I will not hold any staff of Our Place Respite responsible for any injury occurring during the program.

➢ Every reasonable effort will be made to ensure the safety of the participant.

Participant's Physician Name and Number:

_____

Hospital of Choice: _____

Participant Name: _____ Date: _____

Guardian Signature:

_____

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History of Violence

I, _____, as personal representative, legal guardian, next of kin, caregiver, or holding power of attorney for Participant, hereby represent that to the best of my knowledge, _____ has had no history of violence to himself or others, except as noted below:

1. _____
2. _____
3. _____
4. _____

In the event the Participant exhibits violent behavior, I agree to promptly notify the director of Our Place Respite and discuss the appropriateness of continued participation. The decision rests solely with the director.

Participant Name: _____ Date: _____

Guardian Signature: _____

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Photo, Media & Field Trip Release

➢ PHOTOGRAPHS: The participant gives permission for photographs to be taken during program activities for use in publicity, promotion, print, or media for Our Place Respite Ministry, and for identification purposes.

➢ FIELD TRIPS AND OUTINGS: The participant gives permission to participate in field trips by Our Place Respite. Every effort will be made to ensure safety. I voluntarily indemnify and hold harmless Our Place Respite, its employees, and volunteers from any liability arising from participation in field trips or outings.

Participant Name: _____ Date: _____

Guardian Signature: _____

Our Place Respite

Release of Liability

In consideration of _____ (hereinafter "Participant") being allowed to participate in the programs, services, activities, and facilities of Our Place Respite Ministry, I, _____, as personal representative, legal guardian, next of kin, caregiver, or as holding power of attorney for Participant, on behalf of Participant, his or her heirs and assigns, do hereby unconditionally remise, release, and forever discharge and covenant not to sue Our Place Respite or any of their officers, agents, employees, and volunteers from any and all actions, causes of action, suits, debts, claims, liabilities, or damages of any kind, whether for death, personal injury, or property damage, arising or resulting from participation in the programs, services, activities, and facilities of Our Place Respite.

I, for myself and on behalf of Participant, further agree to indemnify and hold harmless Our Place Respite from any and all claims or liability of any kind arising from our participation as aforesaid.

Participant Name: _____ Date: _____

Guardian Signature: _____

Our Place Respite

Enrollment Contract

I, _____, agree to the following regarding enrollment in Our Place Respite Ministry:

1. The Director has explained the admission and enrollment conditions so that I understand them.
2. I agree to inform Our Place Respite staff of any changes pertaining to the participant, including health, mental, and physical status.
3. I agree to arrange or be available for prompt pick-up if my family member or loved one should become ill or disruptive.
4. I agree to keep my family member or loved one out of Our Place Respite if he or she has a fever, flu, or other contagious illness.
5. I agree to participate in requested family meetings when requested by Our Place Respite staff.
6. I agree to notify Our Place Respite staff if my family member or loved one will be absent from the program.
7. I agree that billing statements will be sent at the end of each month. Payment is due within 15 days of receipt via ACH.

Participant Name: _____ Date: _____

Guardian Signature: _____