Helping Hands
Caregiver Resource Center
17645 Penn Valley Dr.
P.O. Box 309
Penn Valley, CA 95946
530.432.2540 phone
530.432.2485 fax
ADCL#297004181

Administrator
Colleen Bond R.N.

Marketing Director
Jennifer Bond

Dear Caregiver,

Thank you for your interest in Helping Hands Caregiver Resource Center, Nevada County's **only** Adult Day Care Program for dependent adults. We offer a variety of socialization opportunities in a family friendly environment. We plan activities with a purpose to nurture each participant's self-esteem and encourage physical activity on a regular basis. Our knowledgeable staff will meet the physical, emotional, and personal care needs of your loved one.

We encourage you to visit the program and observe the calm, satisfying atmosphere in our facility. We would love to have you join us for lunch and experience the warm social interaction shared among participants, staff, and volunteers.

Helping Hands is a place where dignity and self-worth are a priority for everyone, but especially for each participant and caregiver. We want to be an extension of the love and care you provide your loved one and we partner with you to make daily quality of life experiences a reality for those you care most about. We have the privilege of "holding your heart in our hands" and are honored to do so.

To enroll in the program you will need to complete the following:

1. **Enrollment Information Form**
2. **Physicians Authorization Form**
3. **TB Test (included on Physicians Form)**
4. **Participant History (taken in interview with Social Worker)**
5. **Enrollment Agreement (during interview, which includes your individualized contribution commitment to the program)**

You will also need to make transportation arrangements prior to starting the program. If you need assistance with any of these items, or have any questions, please feel free to call us at your convenience.

Sincerely,

Colleen Bond RN

Administrator

Helping Hands
Caregiver Resource Center
Enrollment Information Form

Personal Information Date:_____

CLIENT Name:_____

Home Address:_____ City:_____

State:_____ Zip:_____

Mailing Address (if different):_____ City:_____

State:_____ Zip: _____

Phone:_____ Cell: _____

Date of Birth:_____ Age:_____ Conserved: ☐ Yes ☐ No

CAREGIVER Name:_____

☐ Conservator ☐ POA ☐ Family ☐ Other (explain)_____

Home Address:_____ City:_____

State:_____ Zip:_____

Mailing Address (if different):_____ City: _____

State:_____ Zip: _____

Phone:_____ Cell: _____

EMERGENCY CONTACT:_____ Relationship:_____

Phone:_____ Cell:_____

EMERGENCY CONTACT:_____ Relationship:_____

Phone:_____ Cell:_____

EMERGENCY CONTACT:_____ Relationship:_____

Phone:_____ Cell:_____

We must have at least one alternate contact in the event that the caregiver is unreachable during Helping Hands business hours.

Medical Information

Physician Name:_____ Phone:_____

Dentist Name:_____ Phone:_____

ALLERGIES (drug, environmental, food, other):_____

Primary Medical Diagnosis:_____

SPECIAL NEEDS

Check all that apply:

- ☐ Assistive Device (w/c, walker, cane, other:_____)
- ☐ Assist with MOBILITY (unsteady)

☐ Escort to bathroom	☐ Wears Depends	☐ Hearing impaired
☐ Assist w/ meals	☐ Choke risk	☐ Special diet:_____
☐ Limit fluids	☐ Encourage fluids	☐ Other:_____
☐ Visually impaired	☐ Cognitive impaired	

PARTICIPATION

Check all that apply:

- ☐ Group Exercise (dancing, walks, bowling, ect.)
- ☐ Individual Exercise (on equipment w/ supervision)
- ☐ Activities (arts, crafts, baking, gardening, ect.)

In the event of a LIFE THREATENING EMERGENCY

Check ONE: ☐ YES, begin CPR & call 911

☐ NO CPR, client is a DNR, call Caregiver

In order to be honored, client must have a physician signed DNR on file.

MEDICATIONS

Please list all medications taken during program hours:

Medication Name/Dosage	Time Taken

Does client require assistance with medications? ☐ Yes ☐ No

Medical Administration Permission

I give permission for the trained staff at Helping Hands Caregiver Resource Center to assist my participant with their medication(s) as instructed. I will send their medication on a daily basis in an appropriate container marked with their name and time of administration, or I will supply the program with an original prescription bottle with medication to be kept locked in the medication box at all times and distributed to the participant at the scheduled time.

Responsible Party Signature:_____ Date:_____

Attendance Information

1) For ID purposes, Participant MAY have their photo taken? ☐ Yes ☐ No
2) Expected days of attendance each week: ☐ Monday ☐ Tuesday ☐ Friday
3) Mode of Transportation: ☐ Personal ☐ Tele-care ☐ Gold Country Lift

Photo Release

I give permission to Helping Hands Caregiver Resource Center and the Penn Valley SDA Church to photograph and/or video (participant name)_____ for the purpose of promoting this program through all forms of media marketing, including, but not limited to printed materials, social media, internet site, or television.

Responsible Party Signature:_____ Date:_____

Financial Information

- Our program fee $65/day, which is the current national average costs for Adult Dare Care Programs.
- We offer a Sliding Scale Fee Option to those who qualify.
- We can also accept Participants on an hourly basis if needed.
- We accept VA benefits.
- Sponsorships may be available. Inquire if you think you may qualify.
- We are committed to helping every family find a financial solution that works!

1) Does client currently have MediCal? ☐ Yes ☐ No
2) Do you have another respite care payment option available? ☐ Yes ☐ No

☐ Long-term Care Insurance ☐ Del Oro Resource Center Voucher
☐ Hospice or Transitions Voucher ☐ Alta Regional
☐ Other: _____

All participating families are expected to make a commitment to contribute to Helping Hands in order for us to continue to serve our community. If you need assistance, proof of annual income may be required. Request a Financial Assistance Application Form if you think you may qualify.

- Eligible participants may begin attending immediately.
- Enrollment Information Form (this one) MUST be completed to begin.
- Our Social Worker will make an appointment with you to complete enrollment.
- That appointment can take place at our program or at your home.
- The physician's form and TB testing results must be completed and submitted within 30 days.
- To protect everyone, participants exhibiting symptoms of illness at any time are asked to stay home or may be sent home if our staff determines they are possibly contagious.

Responsible Party Signature:_____ Date:_____

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY:			TELEPHONE:
Helping Hands Caregiver Resource			(530)432-2540
ADDRESS: NUMBER	STREET	CITY	
P.O. Box 309		Penn Valley, CA 95946	
LICENSEE'S NAME:	TELEPHONE:	FACILITY LICENSE NUMBER:	
Penn Valley SDA Church	(530)432-2479	297004181	

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:			TELEPHONE:
ADDRESS: NUMBER	STREET	CITY	SOCIAL SECURITY NUMBER:
NEXT OF KIN:		PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1.	4.	7.
2.	5.	8.
3.	6.	9.

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

Helping Hands Caregiver Resource
P.O. Box 309 Penn Valley, CA 95946

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE:

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	YES (Check One)	NO (Check One)	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO	YES (Check One)	NO (Check One)	COMMENTS:
1. Able to care for all personal needs			
2. Can administer and store own medications			
3. Needs constant medical supervision			
4. Currently taking prescribed medications			
5. Bathes self			
6. Dresses self			
7. Feeds self			
8. Cares for his/her own toilet needs			
9. Able to leave facility unassisted			
10. Able to ambulate without assistance			
11. Able to manage own cash resources			

$65.00 Value!!

HELPING HANDS
Caregiver Resource Center

Licensed ADC #297004181

This Coupon Good for:

One FREE Respite Day!

For Dependent Adults 18 and older

9am - 3pm, Monday or Tuesday only
Lunch Provided. Transportation not included.
Call to RSVP! (530)432-2540

Helping Hands Caregiver Resource Center
17645 Penn Valley Dr, Penn Valley

Limit one coupon per participant **or** household.
Coupon good for new participants only.
This coupon holds no cash value and is redeemable only for the purpose of providing a safe place for a dependent adult while allowing their caregiver one day of respite care. Enrollment Information Form must be completed prior to leaving participant, however full enrollment is not required to use this coupon.

Participant Name:_____

Caregiver Name:_____ **Phone:**_____

Address:_____

Date of Attendance:_____