Merrimack Adult Day
Health Center

Scope and Type of Services Admission Agreement

I, (print name of participant or guardian in the case of an incompetent adult),

_________________________________ agree to enter Merrimack Adult Day Health Center program.

The program will provide nursing care and health supervision using an individualized plan of care. Two meals and one nourishing snack will be prepared in accordance with the physicians' order and served daily. Merrimack Adult Day Health Center will provide, at minimum the following core services and programs as required by He-P 818.15 regulation: Administrative services that include the appointment of a full time Administrator, Nursing services, Recreational activity services, Personal care services, Health and Safety services to minimize the likelihood of accident or injury, with protective care and oversight while the participant is at Merrimack Adult Day Health Center, Social services, which shall be provided by the Administrator, Licensed Nurse, or a Social Worker and Dietary services. A therapeutic program inclusive of Physical Therapy, Occupational Therapy, Speech Therapy as well as educational, social and recreational services will be offered as needed to obtain and maintain the participant's maximum level of functioning. Group and family counseling will be provided with referrals made to community agencies if appropriate.

Merrimack Adult Day Health Center is open Monday through Friday from 8:00am until 4:00pm except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. (Observed holidays not included.)

All caregivers are responsible for participants by 4:00pm at the close of the program day. If a participant remains at Merrimack Adult Day Health Center after 4:00pm, or if the caregiver is not available, the center staff will provide supervision until 5:00pm. If the caregiver has not contacted the center by 5:00pm, the center staff will notify Protective Services of the need for emergency shelter.

In the event of inclement weather or other emergency situations, Merrimack Adult Day Health Center may unexpectedly be closed. Participants and families are encouraged to call Merrimack Adult Day Health Center at (603) 417-6656.

It is understood that:

1. The participant will attend the following amount of day a week ________.
2. The participant will be transported by Merrimack Adult Day Health Center contracted transportation provider in the morning to MADHC from home and in the afternoon from MADHC to home.
3. Participants may choose to provide their own transportation via a relative or care giver. Such a choice must be made clear upon commencement of participation in the Program.
4. In the case of emergency, which hospital does the participant wish to be taken to?

____

5. The participant or caregiver agrees to provide clean clothing articles and disposable briefs, or disposable diapers as needed.
6. The participant/caregiver agrees to contact MADHC by the end of the previous day if the participant is unable to attend the program as scheduled and contact the transportation provider to cancel transportation.
7. The participant/caregiver understands that MADHC does not assume responsibility for valuables or money left in the possession of the participant.

This agreement will remain in effect until discharge.

The following questions will assist us with care planning and coordination.

1. Does the participant have a Legal Guardian? Yes ____ No____
2. Does the participant have a Power of Attorney? Yes ____ No____

If yes, please list the following:

Name: ____

Address: ____

Phone Number: ______________________________

Does the participant have the following:

1. An Advanced Directive (etc)?
2. DNR status? Yes ____ No____
3. Living will? Yes ____ No____
4. Health Care Proxy? Yes ____ No____

If Yes was checked to any of the above legal documents, please provide a copy to MADHC.

The participant or caregiver was offered and educated on the POLST form. Yes ____ No____
The participant or caregiver was offered and educated on the Health Care Proxy form. Yes ____ No____

I have received a copy of Patients' Rights, Complaint Procedure, Medication Policy and Scope and Type of Services Admission Agreement. Yes ____ No____

I consent to the release of this agreement to appropriate health and social agencies in the event of an emergency.

_______________________________________ _______________________________

Participant's/Legal Representative's Signature Date

_______________________________________ _______________________________

Staff Signature Date