ENROLLMENT PROCESS AND HIPPA POLICY
Caring Connection Adult Day Health Center
Town of Windsor
330 Windsor Avenue
Windsor, CT 06095
860-547-0251 (Tel) 860-547-0254 (FAX)

Enclosed you will find forms which must be completed fully before enrolling in the Caring Connection Adult Day Health Center. The information obtained in these documents will help us provide the most comprehensive and appropriate care possible.

1. **PHYSICIAN'S MEDICAL AND ORDERS FORM:** This form is completed and signed by your physician. It is based on a medical evaluation prior to the participant's enrollment. (Facsimiles and copies of W-10s are acceptable.) Also, regulations require that you sign a "medical release form" allowing us to consult with your physician on a regular basis regarding care and a "medication policy form" giving us permission to dispense prescription medications.
2. **ADMISSION ASSESSMENT AND RELEASES:** This form serves as a tool to educate staff about participants' needs and preferences. Also included are releases and agreements as outlined in the Connecticut Association of Adult Day Center standards for the Center's certification. ***All forms must be completed and signed.***
3. **FINANCIAL RESPONSIBILITY AND INCOME VERIFICATION FORMS**: These documents outline your financial obligations to The Caring Connection. They ***must*** be read, signed and dated by you or your financially responsible party.

REMINDER: All forms must be signed and returned to the Caring Connection no less than 48 hours prior to the planned admission date.

HIPAA POLICY

The Health Insurance Portability and Accountability Act of 1996 is a federal program that requires all medical records and other individually identifiable health information is protected and disclosed (electronically, on paper, or orally) only according to law.
Our responsibilities include:

- Making certain your medical information is protected as dictated by law.
- Notifying you if we are unable to agree to a requested restriction.
- Accommodating reasonable requests you may have to communicate health information to alternative locations (by written release).

Also, we may use or disclose your personal health information in order to provide you with services and treatment you require or request, to collect payment for those services and to conduct other related health operations otherwise permitted or required by law.
You have the right to:

- Request information about the use and disclosure of your health information for treatment and payment.
- Limit communications to receive your own information by alternative means or alternative locations (by written request).
- Inspect and have copies made of your health records by submitting a written request to the Caring Connection Coordinator or Nursing Coordinator.
- File a complaint with the Federal Department of Health and Human Services if you believe your privacy rights have been violated within 190 days.

Should our information practices change, we will provide new provisions effective for all protected information to you via mail.

Signature _____ **Date** _____

PHYSICIAN'S INTRODUCTORY LETTER
Caring Connection Adult Day Health Center
Town of Windsor
330 Windsor Avenue,
Windsor, CT 06095
860-547-0251 (Phone) 860-547-0254 (FAX)

Date: _____

Dear Dr._____ :

Your patient, _____, has indicated an interest in attending the Caring Connection Adult Day Health Center.

Enclosed please find:

- **Medical Information and Orders Form** that must be returned to the Caring Connection prior to the admission of a client to the program (and annually thereafter).
- **Standing Orders are included on this medical form;** If these orders are contraindicated for your patient, please advise.

The Caring Connection Adult Day Health Center uses humanistic, interdisciplinary approaches that emphasize individual programming designed to meet our client's physical, mental, and emotional needs. Our services include transportation to and from the center (Windsor and surrounding communities), therapeutic recreation, nursing services and medication management, personal care services, including requests for showers, two snacks and one hot lunch.

Your input is a valuable part of our admission process as it is used to develop a comprehensive treatment plan designed to keep our clients safe and healthy in a community setting. We will be in contact with you annually for updates on treatment orders and medications. Clients cannot be admitted to the Caring Connection program without this form upon admission and annually thereafter.

Please complete the attached medical form, enclose a current medication list and return them to the Caring Connection as soon as possible so not to delay the admission of your patient to the program. The document can be faxed to 860-547-0254.

If you have any questions or concerns regarding our services and/or your patient, please feel free to call us at 860-547-0251.

Thank you,

Cheryl Rosenbaum, Coordinator
Caring Connection Adult Day Health Center

The Caring Connection Adult Day Health Center
Town of Windsor
330 Windsor Avenue
Windsor, CT 06095
Tel: 860-547-0251 or Fax: 860-547-0254

Date: _____

To: Dr. _____

_____

_____

Dear Dr. _____:

I, _____, hereby authorize you to release information regarding the physical and mental status of your patient _____.

I also authorize the sharing of information about my status between you and a representative of the Caring Connection staff while I am a participant of the program.

Sincerely,

_____

(Signature of participant, caregiver, conservator, or POA) (Date)

_____

(Relationship)

Name of Center **Participant's Name:** _____

Caring Connection Adult Day Health Center
330 Windsor Avenue
Windsor, Connecticut 06095
TEL: 860-547-0251 FAX: 860-547-0254 **DOB:** _____

Physician Assessment:

DIAGNOSIS: _____

_____

_____

_____

DIET: _____

_____

_____

ACTIVITY LEVEL: Able to participate in daily exercise without restrictions_____
List any restrictions, limitations:_____

_____

NURSE MAY ADMINISTER:

_____Tylenol 500MG 2 tabs p.o prn pain / temp > 101
_____Influenza vaccine 1cc IM annually
_____Finger stick PRN

Medications (may be administered at the Caring Connection if needed)

Name of Medication	Dosage	Frequency, Route	May Administer at CC	YES	NO
			May Administer at CC		
			May Administer at CC		
			May Administer at CC		
			May Administer at CC		

***Please attach a list of current medications**

ALLERGIES: _____

TREATMENT: Cleanse any wound with normal saline and apply bacitracin and dressing PRN If needed, may change daily until healed.

Pending TB risk assessment: blood test or chest x-ray_____

This patient is free of infectious disease Yes _____ No _____ **If no please explain:**

_____

_____

Date of Last Vaccination: Tetanus: _____ Pnuemovax:_____ Flu Vaccine:_____

Baseline Vitals Signs: BP_____ P_____ R _____ HT _____ WT _____ Date:_____

I certify this patient to be appropriate for and able to benefit from the Adult Day Health Center
Yes _____ No _____

THE ABOVE ORDERS ARE IN EFFECT FOR 1 YEAR UNLESS OTHERWISE NOTED

_____

Physician's Printed Name **Physician's Signature** **Date**

Address:_____ **Phone:**_____

_____ **FAX:** _____

The Caring Connection Adult Day Health Center
Town of Windsor
330 Windsor Avenue
Windsor, CT 06095
Tel: 860-547-0251 or Fax: 860-547-0254

ADMISSION ASSESSMENT FORM

Date: Admission Date:
Name: Home # ( ) Cell # ( )
Address: APT.
Town: State: Zip:
SS# - - Medicare #: Title 19#:
Long Term Insurance Company – policy #
Home Care For Elders Program Yes No Case Mgr. phone:
DOB / / Birthplace Town: State:
Marital Status: S D M W Former Occupation: Religion:
Veteran: Yes No VA Benefits: Yes No Education:
Living Arrangements: *Alone* *Spouse* Other:
Number of Children: Housing:
Attendance Days: M T W TH F = _____ days
Transportation: Caring Connection AM PM Family AM PM
Assist required during transporting:
Primary Physician: Telephone #:
Address: **Hospital**:
Other Physicians:
Allergies:
Medical History:
Do Not Resuscitate Bracelet: Yes No **Living Will:** Yes No (If yes please provide copy)
DIET: DIABETIC – Insulin Dependent No Salt No Sweets Soft Modified Soft Cut up Other:
VISION: HEARING: Hearing Aid: L R
SPEECH: Clear Slurred Aphasic Other:
COGNITION: Understands Needs Cueing Poor Judgment
MEMORY: Short Term Good _____ Fair _____ Poor _____
Long term Good _____ Fair _____ Poor _____
EMOTIONAL STATUS:
BEHAVIORAL STATUS:
MOBILITY: Assistive Devices:
RECENT FALLS Y N # Special Accommodations:
GROOMING & PERSONAL CARE: Independent With Assist
SHOWERING SERVICES AT CARING CONNECTION: No Yes
TOILETING: Independent _____ Assist _____ Incontinence: Bowel and / or Bladder

PERMISSION TO PHOTOGRAPH: *I give or refuse permission for the Caring Connection to take photos and / or videos for publicity purposes.*

RESPONSIBILITIES: *I understand that the Caring Connection is not responsible for lost or stolen items brought to the center (valuables, money, jewelry, clothing). I understand that I am responsible for reporting any changes in condition, medications, injuries, days of service and absences to the Caring Connection Staff. I have received a copy of the policy of HIPAA.*

Signature **Date**

Client / Responsible Party

Signature **Date**

Nurse

The Town of Windsor's Adult Day Health Center
The CARING CONNECTION
330 Windsor Avenue
Windsor, Connecticut 06095
(860)547-0251 FAX(860)547–0254

EMERGENCY CONTACTS

Client Name: _____

Address: _____ State _____ ZIip _____

I hereby authorize immediate medical emergency care if necessary for _____ at the Caring Connection. I also will accept responsibility for emergency care at _____ Hospital and am responsible for all associated fees.

In Case of Emergency/Illness or building closure.

1. **First Contact**: _____
   Address: _____
   _____
   Home phone: _____ Cell Phone: _____
   Email address: _____
   Place of Employment: _____ Town: _____
   Work Phone: _____

2. **Second Contact**: _____
   Address: _____
   _____
   Home phone: _____ Cell Phone: _____
   Email address: _____
   Place of Employment: _____ Town: _____
   Work Phone: _____

3. **Third Contact**: _____
   Address: _____
   _____
   Home phone: _____ Cell Phone: _____
   Email address: _____
   Place of Employment: _____ Town: _____
   Work phone: _____

4. **Fourth Contact**: _____
   Address: _____
   _____
   Home Phone: _____ Cell Phone: _____
   Email address: _____
   Work Phone: _____
   Place of Employment: _____ Town: _____
   Work Phone: _____

_____ _____
Signature Date

The CARING CONNECTION Adult Day Health Center
Town of Windsor
330 Windsor Avenue
Windsor, Connecticut 06095
860-547-0251 (Tel) 860-547-0254 (FAX)

FINANCIAL RESPONSIBILITY

Participant's Name: _____
Address: _____
Telephone Number: (_____)_____

Financial Responsible Party:
_____ Connecticut Community Care, Inc. (billed directly)
_____ Private Pay
_____ Veterans Administration
_____ Department of Social Services; including protective services
_____ Long Term Health Insurance (Company and policy # _____)
_____ Other

Private Pay Financial Responsible Party:
Name: _____
Home # _____ Work# _____ Cell #_____
Billing Address: _____
_____
Relationship to Participant: _____

I agree to pay for the service of the Caring Connection at the rate of **$85.00 per full day** and **$55.00 per half day** for as many days as the participant attends the program within any given month.
I agree that I will be billed on a monthly basis and agree to pay within 14 days of receipt.

Half days: AM session-ends promptly at 12:30 pm.
PM session begins absolutely no earlier than 11:00 am.

Checks will be made payable to The Caring Connection

I understand that I will not be billed for the days that I am absent from the program, including illness or leave of absence. I understand that charges will be adjusted or waved for scholarship or grant funding monies according to availability and financial hardship at the end of each month.

All outstanding charges must be received within 60 days of the billing or outstanding delinquent accounts will be turned over to the Town of Windsor Attorney for collection. After that time, clients may be discharged from the program for nonpayment.

_____ _____
Signature Date

Caring Connection Adult Day Health Center
Town of Windsor
330 Windsor Avenue,
Windsor, CT 06095
860-547-0251 (Tel) 860-547-0254 (FAX)

AGREEMENT OF RESPONSIBILITY

This is an agreement between myself/client and or responsible party for myself/client or individual attending the Caring Connection Adult Day Health Center.

Please check one of the following:

_____I am the responsible party for myself.
_____I am the responsible party managing the affairs of the individual attending the Caring Connection.
_____I am the Power of Attorney and have been court appointed to manage the financial and/or medical affairs of this individual.
_____I have been appointed by Probate Court as the Conservator assigned to manage the individual's estate and making health care decisions on behalf of this client.
_____I am a relative or friend of this individual and am managing his/her financial and health care decisions.

I understand that my signature at the end of this admission is my acceptance to comply with the Caring Connection policies and that I am the responsible party or myself or the client attending the center.

CLIENT INCOME VERIFICATION FORM

This information gives the administration of the Caring Connection the ability to apply for grants to assist clients with financial hardship, scholarship assistance, or apply for grants to purchase goods and services for our program. This information will be kept confidential and is used for statistical information.

Name: _____
Address: _____
_____

My total monthly income is: $_____

In support of the income I have certified above, I understand that this information will be used to determine if I am eligible for participation in funding in the North Central Area Agency on Aging Title lllB funding, Hartford Foundation for Public Giving, Granger, or the Department of Social Services Medicaid Waiver Program, and to establish an anonymous data base of client income for program funding.

I understand that this information is for funding purposes and will be kept confidential.

Signature _____ Date _____

Caring Connection Adult Day Health Center
Town of Windsor
330 Windsor Avenue,
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860-547-0251 (Tel) 860-547-0254 (FAX)

PRIVATE PAY BILLING POLICY

Scheduled participants will be billed for actual days of attendance.
Participants will not be billed if:

1. The participant or responsible party calls to cancel prior to departure for morning pick up (before 8:00 am) and the participant is not brought to the center.
2. The participant is on vacation.
3. The participant is on hold due to hospitalization, extended illness or temporary residence outside the geographic area.

Items #2 and #3 correlate to our discharge policy. If a participant is absent for six consecutive weeks, a place will not be held. The participant will automatically be discharged from the program and placed on a wait list if the program is filled to capacity. A discharged participant may return to the program when there is a vacant place and medical records are updated.

Late arrivals or early departures due to illness, appointments, etc. are billed as full days (to participants with care planned full days) if the following criteria exist:

1. The staff is scheduled to meet the one/7 ratio
2. A lunch has been ordered
3. Transportation has been attempted or received for at least one trip (to or from the program). ***Therefore, it is important to notify the Caring Connection of a cancellation before the busses depart at 8:00 am.***
4. Nursing, therapy, social work, or recreation services have been received

Hours of operation are from – 7:00 am to 4:30 pm.

The criteria for care planned a half day schedule are:

- The AM session begins as early as 7:00 am and ends promptly at 12:30 pm
- The PM session begins no earlier than 11:00 am and ends no later than 4:30 pm

Please be aware that bus transportation for the 11:00 am and 12:30 pm half day time criteria is dependent upon the Dial-A-Ride schedule. The Dial-A-Ride service may not be able to accommodate the half day time requirements.

Foot care services on unscheduled days: Services may be utilized without billing for a Caring Connection attendance if the responsible party transports the participant to and from the program and remains at the Caring Connection while the service is being provided. A second option is to pre-arrange an exchange with a scheduled day.

_____ _____

Responsible Party Signature Date

The Caring Connection Adult Day Health Center
Town of Windsor
330 Windsor Avenue
Windsor, CT 06095
Tel: (860) 547-0251 Fax: (860) 547-0254

AUTHORIZATION TO RELEASE AND RECEIVE INFORMATION

I authorize the Caring Connection Adult Day Health Center to release, share and receive information regarding the mental and physical health of the below listed client while the said client is a participant in the Caring Connection Adult Day Health Center Program.

Name of Client _____ DOB _____

Client or Authorized Signer _____

The Caring Connection Adult Day Health Center
THERAPEUTIC RECREATION PRE-ASSESSMENT
To be completed prior to admission

In order to provide a well-rounded therapeutic recreation program based on the needs and interests of individuals, we are including a Therapeutic Recreation Assessment Form to be completed and returned with our admission packet.

Please indicate past and present interests, hobbies, community involvement and/or any additional information so that we can access ones involvement in our recreation program and care plan. Our recreation programs are outlined in the monthly newsletter. A daily comprehensive therapeutic recreation program is designed for large or small groups, or around individual's needs. Recreation is designed to meet the physical, mental and spiritual needs of our clients. If you have any questions regarding this form or any suggestions, please contact the Therapeutic Recreation Director of The Caring Connection.

Name _____ Spouse's Name if applicable _____

Children _____ Grandchildren_____

Where client grew up: _____ Former occupation(s) _____

Veteran? _____ Y / N War _____ Branch of the Service _____ Religion _____

Animals (like / dislike) (allergy yes / no) Pets _____

_____

<u>Interests</u>: Please indicate: N =NEVER C = CURRENT P = PAST

Art _____ type: _____ Arts and Crafts _____ Bingo_____ Cards Y/N

(card games) _____ Board Games _____ type: _____

Cell phone / Computer / Tablet / Internet (circle) Cooking / Baking _____

Circle any that apply: Crocheting / Knitting / Needlework / Sewing / Hook rug / Other _____

Dominoes _____ Dancing _____ Exercise _____type: _____

Gardening Indoors / Outdoors _____ Movies_____ type:_____

Music listening _____ Type: _____ (choir)_____

(If instrumentalist, please list instrument(s): _____ Puzzles _____ Type: (word or jigsaw)

Reading _____ (types: books, magazines, newspapers) Sports _____ participate / watch

(type of sports & teams) _____

TV _____ (favorite types of shows) _____

Other leisure activities part of the present daily routine: _____

_____

Name of person completing form: _____relationship to client _____

The Caring Connection Adult Day Health Center
Town of Windsor
330 Windsor Avenue
Windsor, CT 06095
Tel: (860) 547-0251 or Fax (860) 860 547-0254

TRANSPORTATION

Transportation is provided to clients in the immediate geographical area of The Caring Connection. Clients are put onto the morning and/or afternoon transportation schedules based on location and request of services. Caring Connection will take into consideration special needs of caregivers and will accommodate pick up and drop off times, if possible.

Clients may be released from the transportation system for any reason assessed by the Caring Connection staff that could include the following: Inappropriate behavior, inability to maintain and understand safety issues, removal of seatbelts, and illness affected by riding in the vehicle. Caregivers and families have the option of dropping off and picking up clients between the hours of 7:00 am and 4:30 pm. The daily rate for clients includes transportation, but does not change if transportation is not utilized.

- **Driver Training:** Drivers are licensed with a public passenger or commercial driver's license and are trained in Caring Connection procedures in case of emergencies. Drivers are also required to attend safety driving courses as per the Town of Windsor's regulations.

- **Maintenance of Vehicles:** All vehicles are required to meet ADA accessibility specifications for transportation vehicles. Vehicles are maintained and repaired on a regular basis and comply with state and federal requirements.

- **Driver Assistance:** Driver assistance is *door to door.* Drivers are responsible for ensuring the safety of their passengers in the use of seat belts. *Drivers are not required to enter residences to retrieve clients and belongings prior to boarding or upon return to the residence at the end of the day.* Drivers cannot leave their vehicles out of their vision at any time.

- **Emergency Equipment:** Cellular phones are available in each vehicle as a use for communication. Each vehicle contains a manual of emergency procedures and information on each client.

The client is safe home alone: Yes_____ No_____

If the client elects to participate in an out trip, do you want to be notified? Yes____ No____
Is email okay for this information.?

I give authorization to utilize the transportation service provided by the Town of Windsor and The Caring Connection. This includes transportation to and from the facility and on out trips. I release The Caring Connection from any liability connected with the transportation provided.

Signature _____ Date _____

The Caring Connection Adult Day Health Center
Town Of Windsor
330 Windsor Avenue
Windsor, CT 06095
Tel: (860) 547-0251 Fax (860) 547-0254

MEDICATION POLICY AND CONSENT FORM

Responsibilities of client or responsible party

1) Physician's order
   (a) Prior to admission, The Caring Connection must have a signed written order from the physician with the participant's full name, medication name, dosage, frequency, instructions for all medications. ***Please note: The order must state medications can be given at Caring Connection.**
   (b) The order is to include the same information for all PRN medications.
   (c) A physician's order is required before medications can be administered at the Center.
   (d) Please be advised: Tylenol can be administered, if needed, because it is on the annual admission medical form.

2) Changes in Medication
   (a) Any changes in medications including increases, or decreases, in all ongoing medications or new medications require immediate notification to the nurse, via family followed by a signed physician's order.

3) Labeling of Medications
   (a) All medications taken at The Caring Connection must be in the labeled container issued by a licensed pharmacist. The label shall include a date and directions.
   (b) Labels must be legible – worn, torn, or dirty labels must be replaced by the pharmacist.

4) Delivery of Medication to The Caring Connection
   (a) Whenever possible and appropriate, all medications shall be delivered to The Caring Connection by a pharmacy, a participant, or a participant's responsible person.

   When the above cannot be carried out, a Caring Connection nurse may give the responsible party permission to deliver the medication via a Caring Connection bus driver who will in turn deliver such medications to the nurse in charge.

5) Self-Administration of Medication
   (a) To be considered capable of self-administration of medications, a participant shall be able to:
      (1) Identify the medication.
      (2) Acknowledge the amount of, and schedule for, medication.
      (3) Remember to take the medication on schedule with infrequent reminders from the staff.
      (4) Obtain medication from its container without assistance or with minimal assistance.
   (b) Medications brought to The Caring Connection for self-administration must comply with the information in #3 above.

6) A PPD may be administered by Nursing Staff on Admission or Annually, as needed.

7) CONSENT FORM – This form must be signed for medications to be administered by nursing staff.

I have read the medication policy and agree to the terms and conditions therein and give the nursing staff permission to either give _____his/her prescribed medication(s) or the client may self administer their medication(s) based on the terms in section 5 above.

_____ Date: _____
Signature of Participant or Responsible Party

The Caring Connection Adult Day Health Center
Town Of Windsor
330 Windsor Avenue
Windsor, CT 06095
Tel: (860) 547-0251 Fax (860) 547-0254

DISCHARGE CRITERIA / PLAN

PURPOSE: The discharge plan is an on-going consideration of the plan of care that reviews the client's eligibility for the program. It is viewed as a time of transition requiring support in the process of change. Refer to the written "Eligibility" and "Non-Eligibility Criteria".

TYPES OF DISCHARGE and NOTIFICATION REQUIREMENTS

Emergency Discharge: A client's condition or extreme behavior makes it dangerous to the individual or others. Conditions include:

1. Communicable disease, uncontrollable incontinence and ambulation or transfer, which is unmanageable or unsafe to the client or the staff.
2. Extreme behaviors include violent or abusive behavior that may lead to injury, intentional or continuous behaviors that disrupt the program or upset clients, and unmanageable wandering.

   Emergency Discharges can be immediate and without two week notice. Communication with the caregiver at the onset of the identified behavior and documentation are required. Emergency discharges may be rescinded if, in the Opinion of the planning team, treatment has brought the condition under control. In this case, the client is placed on hold pending expected improvement.

Planned Discharge: A person's ongoing plan of care for discharge if optimum or negative conditions occur. These plans include a summary of recommendations and referrals and are documented on the 6 month reviews.

1. Optimum conditions are an improvement in functional abilities requiring a more independent setting.
2. Negative conditions indicate the need for care beyond that which the day center can provide requiring another level of care. This is often due to deterioration in health and includes death.

Oral or Written notification by The Caring Connection Center may be made to the client or the responsible party or both at least two weeks in advance of the planned discharge.

- Voluntary Discharge: Clients leave for personal reasons. Some of these reasons are relocation, choice of another level of care, desire to function without care, and lack of funding resources.

Written notification of expected withdrawal is required from the client and/or responsible party for voluntary discharge two weeks in advance.

HOLD AND WAIT LIST: After *6 weeks* of absence or placement on hold, the client will be placed on a waiting list if the program is filled to capacity and a waiting list already exists.

Discharge Procedures:

1. All significant changes must be documented as it occurs and communicated with caregivers and case managers.
2. A discharge summary, including recommendations for continuing care and referrals shall be included in each 6 month review.
3. Referrals to community agencies for appropriate services shall be made at the time of discharge.
4. Follow up shall occur as needed until the case is closed.
5. Documentation for discharge shall include date, reasons, referral sources, and the implementation of the plan. Documentation is filed with the client records and retained for no less than 7 years.

_____ _____

(Signature of Client or Responsible Party) Date

The Caring Connection Adult Day Health Center
Town Of Windsor
330 Windsor Avenue
Windsor, CT 06095
Tel: (860) 547-0251 Fax (860) 547-0254

CLIENT BILL OF RIGHTS

The Caring Connection recognizes that you have certain rights and responsibilities in your relationship with the Center and it's staff. It is our intention to deliver your health care with the thoughtful behavior described below:

1. You have the right to be treated with respectful care, dignity, and consideration by all staff.
2. You have the right to expect quality health care and high professional standards.
3. You have the right to every consideration of your privacy concerning your care. Examinations, treatments, and discussions concerning your care will be conducted discreetly and handled confidentially.
4. You have the right to confidentiality of all records pertaining to your care plan, except as otherwise provided by law, or by your agreement to arrangements with the third party payers.
5. You have the right to consent, or to refuse, any treatment prior to its beginning, having been informed of the medical consequences of either decision.
6. You have the right to attend any team meetings concerning your care plan and to participate in the development and implementation of your care plan.
7. You have the right to know the daily cost of the program and all services included in this cost. You have the right to know all services not included in the daily rate and the cost of those services. You have the right to be fully informed regarding the services provided, the frequency of services and treatment objectives.
8. You have the right to know what Center rules and regulations apply to your conduct as a participant.
9. You have the right, upon written request, to have access to information in your records.
10. You have the right to aesthetically pleasing and safe physical accommodations involving as much as possible, individual choice and control.
11. You have the right to express grievances and recommend changes and to be free from abuse, neglect, exploitation and restraint.
12. You have the right to refrain from or to participate in religious or other program activities.
13. You have the right to participate in the assessment and planning of The Caring Connection program via surveys and The Caring Connection Council.

YOUR RESPONSIBILITIES

1. To stay in contact with my physician, keep appointments and report changes in medications, treatments, conditions or needs via support services or on my own.
2. To inform the Center of any changes in attendance schedule, telephone numbers, and changes in conditions and medications.

Signature _____ Date _____

The Caring Connection Adult Day Health Center
Town Of Windsor
330 Windsor Avenue
Windsor, CT 06095
Tel: (860) 547-0251 Fax (860) 547-0254

Grievance Procedure

The Town of Windsor's Adult Day Health Center has adopted an internal grievance procedure providing an equitable resolution of complaints alleging any action prohibited by the United States Department of Public Health, Section 504 of the Rehabilitation Act of 1973 which states, "no otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." The law and regulations may be examined in Administrative Offices by the following procedures:

1. A complaint be in writing, containing the name and address of the person filing it, and briefly describe the action alleged.

2. The complaint is to be filed in the office of the Coordinator of the Program within a reasonable time after the complaint is alleged.

3. The Coordinator shall conduct an investigation of the complaint as may be appropriate to determine its validity. These rules contemplate informal, but thorough investigation, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the complaint.

4. The Coordinator shall issue a written decision determining the validity of the complaint no later than 30 days after its filling.

5. The Coordinator shall maintain the files and records of The Caring Connection ADHC relating to complaints filed hereunder. The Coordinator may assist persons with the preparation and filing of complaints, participate in the investigation of complaints, and advise the Director of Human Services and/or Human Resources concerning the resolution.

6. The resolution shall be presented to the named party in writing after review of the Coordinator and the Director of Human Resources and/or Human Services.

_____ _____

Signature Date

U.S. Department of Agriculture Adult Day Care
Food Program Income Eligibility Forms

The Income Eligibility Application on the next page of this packet gives the Caring Connection financial information in order to receive reimbursement from the federal government through the State of CT Department of Education for 1 lunch and 2 snacks that are provided by the staff at The Caring Connection.

This information you provide will be treated confidentially and will be used only for eligibility determination. Regardless of income, clients are rated as under reduced and over income. The Caring Connection receives reimbursement based on all income levels, but does not receive reimbursement if a meal or snack is refused when offered to the client.

If you have any questions regarding this form, please speak to the Coordinator of The Caring Connection.

An important message from our coordinator:

Winter in New England brings some stormy weather. Stormy weather presents some challenges and concerns about the safety of our clients and staff in their comings and goings from The Caring Connection. Please be aware of the following information on days when winter storms are a part of our experience.

- The Caring Connection will usually be open in stormy weather unless the Town of Windsor actually closes down all Town activities except for Emergency Management
- Listen to the radio. If the School System in the Town of Windsor is closed, that means that The Caring Connection will **not** have bus transportation to our program for that day. We may still be open to fulfil your needs. You would be expected to provide transportation for your loved one both to and from the program on stormy days when the transportation is closed.
- On stormy days, a member of The Caring Connection team will contact you as early as possible, usually between 7:00AM and 7:45AM. We will inform you if the bus is running and whether or not we are open or closed (If the storm problem is dangerous ice, then we may elect to close for the safety of our staff).
- In any case, we will make every attempt to notify the appropriate individual for each client regarding our plans for the day in a timely enough fashion to allow the responsible parties for our clients to make informed decisions.
- So, please note, on mornings when there is a possibility that we may be trying to reach you regarding weather concerns, we ask that phones be answered or at least voice message options be available to us.
- If the weather turns bad or is predicted to do so, and we must close early, we will call all responsible parties and make appropriate arrangements.
- In order that we have the best possible contact information for each of our clients, please check with us if you have had any changes over the past year in phone numbers or whichever family member is the best to call.

IF WE CAN'T REACH YOU, WE CAN'T KEEP YOU APPROPRIATELY INFORMED

Thank You from the Caring Connection Staff

Cheryl Rosenbaum
Caring Connection Adult Day Health Center
330 Windsor Ave
Windsor, CT 06095
Tel. 860-547-0251
Fax 860-547-0254

Child and Adult Care Food Program (CACFP)

INCOME ELIGIBILITY APPLICATION FOR ADULT DAY CARE CENTERS

For instructions, see *Instructions for Income Eligibility Application for Adult Day Care Centers*.

PART 1 — PARTICIPANT INFORMATION

Participant's Name: _____ Age: _____ Birth Date (*month, day, year*): _____

PART 2A — PARTICIPANTS CATEGORICALLY ELIGIBLE AS FREE FOR CACFP BENEFITS

Households receiving Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps), Supplemental Security Income (SSI) or Medicaid: *Complete this part and part 3. Do **not** complete part 2B.*

SNAP Case Number: _____ SSI Identification Number: _____

Medicaid Identification Number: _____

PART 2B — ALL OTHER HOUSEHOLDS

If you did not complete part 2A, complete this part and part 3.

Names of all household members *List **everyone** in the household, including the participant listed in part 1 above*	**Gross income and how often it was received:** Indicate if income was received monthly, two times a month, every two weeks or weekly by placing the **amount of income** in the appropriate frequency box. *You **must** place the income in the appropriate frequency box.*											
	Earnings from Work (before deductions) – Job 1				**Public Assistance/ Alimony/Child Support**				**Pensions/Retirement/Social Security/All Other Income**			
Names	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly	Weekly	Biweekly Every 2 weeks	2 X Month	Monthly
(Example) Jane Smith	$200					$134						
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												

PART 3 — CONTACT INFORMATION, SIGNATURE AND SOCIAL SECURITY NUMBER

*An adult household member must **sign and date** this form before it can be approved.*

I certify (promise) that all information on this form is true and that all income is reported. I understand that the center will receive federal funds based on the information I provide. I understand that CACFP officials may verify (check) the information. I understand if I purposely give false information, the participant may lose meal benefits, and I may be prosecuted under applicable state and federal laws.

Printed Name of Adult: _____ Signature: _____

Date: _____ Last four digits of Social Security Number (SSN): XXX-XX- _____ ☐ I do not have a SSN

Home Telephone: _____ Work Telephone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

PART 4 — RACIAL AND ETHNIC IDENTITY (OPTIONAL) *You are not required to complete this part.*

Ethnicity ***(Check one):***

☐ Hispanic/ Latino
☐ Not Hispanic/Latino

Race ***(Check one or more):***

☐ Asian
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander

CACFP INCOME ELIGIBILITY APPLICATION FOR ADULT DAY CARE CENTERS, continued

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

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FOR SPONSOR USE ONLY – DO NOT WRITE BELOW THIS LINE

Annual Income Conversion: Weekly X 52 • Every 2 weeks X 26 • Twice a Month X 24 • Monthly X 12

Total family income: $ _____ Family size: _____ **OR** ☐ SNAP/SSI/Medicaid household

☐ Eligible Free ☐ Eligible Reduced ☐ Over Income

Sponsor Eligibility Official: _____ Date: _____
Signature

CSDE
CONNECTICUT STATE DEPARTMENT OF EDUCATION

For information on the CACFP, visit the CSDE's CACFP website or contact the CACFP staff in the Connecticut State Department of Education, Bureau of Health/Nutrition, Family Services and Adult Education, 450 Columbus Boulevard, Suite 504, Hartford, CT 06103.

This form is available at
http://portal.ct.gov/-/media/SDE/Nutrition/CACFP/Forms/IncElig/IEAppAdult.pdf