The Next Chapter Daytime Senior Care & Activities

MEMBER INFORMATION

Name	Sex	DOB	Nickname
Address			Seasonal Yes / No
City	State	Zip	
Marital Status	Home Phone	Cell Phone	
Social Security Number	Email		

PHYSICIAN INFORMATION

Name		Type of Physician	
Address			
City	State	Zip	
Phone	Fax	Email	
Medical History (Please include major illnesses, major surgeries, hospitalizations within the last 2 years)			
Allergies			
Diet Restrictions			
Preferred Hospital Name	Address		

REPRESENTATIVE INFORMATION

Name		Email	
Relationship (check all that apply) _____ Spouse _____ Healthcare POA _____ Financial POA _____ Legal Guardian _____ Family _____ Friend			
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
2nd Emergency Contact Name	Cell Phone	Other Phone	
3rd Emergency Contact Name	Cell Phone	Other Phone	

The Next Chapter Daytime Senior Care & Activities
13280 Northwest Fwy Ste F 393
Houston, TX 77040
(585) 520-9383
www.nextchapterdaytimeseniorcare.com

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SERVICES AGREEMENT

This agreement is made this _____ day of _____ month _____ year, between Next Chapter Assisted Living, LLC and _____ (participant name also referred to as the "member").

BILLING AND PAYMENT

*By initialing, I am indicating that I have already utillized or plan to utilize the free Guest Pass.

_____ Guest Pass

The "guest pass" is to be used on the day of your choice and is considered to be the first day a participant attends the center. There is no fee for services on the day of a guest pass. Each participant is limited to one "guest pass."

By selecting the "guest pass" option, there is no long-term commitment or a financial obligation for that specific day. The services provided when using a "guest pass" include but are limited to ***activities, assistance with the activities of daily living, meals and drinks*** rendered on the first day of attendance.

*By initialing, I am indicating that I have read and understand the terms of this billing and payment option. I understand that I have the flexibility to choose between an hourly or monthly membership option depending on my needs.

_____ Hourly Membership

Our weekly billing period runs Sunday - Saturday. Any day care hours, transportation, hair, nails, showers or other ancillary services will be billed for services rendered the previous week.

Typically this billing will take place on Tuesday but could happen any day after the weekly billing period. All hours are billed in 15-minute increments and are rounded to the nearest 15 minutes.

*By initialing, I am indicating that I have read and understand the terms of this billing and payment option. I understand that I have the flexibility to choose between an hourly or monthly membership option depending on my needs.

_____ Monthly Membership

Any hours over the allotted hours during the month will be charged at the discounted hourly rate at the end of each month. Hours missed during the week can be made up anytime during the month. Hours do not roll to the next month. Total monthly hours will be added together at the end of each month.

The number of hours over the allotted hours will be indicated on the invoice as "additional hours." Each invoice will be generated on the 1st of the month and will include two amounts; (1) advance billing for the upcoming month, (2) additional hours from the previous month *(if any)*.

A 30-day written cancellation notice is required to terminate the monthly membership. All hours are billed in 15-minute increments and are rounded to the nearest 15 minutes.

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GENERAL CONDITIONS

Next Chapter Assisted Living, LLC is not responsible for participant's personal property. Such property includes, but not limited to, dentures, eyeglasses, hearing aids, jewelry, wallets, purses, and pocket money. Participants are encouraged not to bring unnecessary items to the center. All personal items should be marked with a permanent marker to avoid loss.

The participant or responsible party signing this agreement (if any) agrees to abide by all the terms and conditions set forth in this agreement. The participant or responsible party signing this agreement hereby acknowledges the following:

1. That each party has received a duplicate of this agreement and any attachment thereafter.
2. That each party has been given an oral explanation of the services provided by the center and charges, including those services offered on an as-needed basis.

HOURS OF OPERATION

Our center is open Monday to Friday from 8:00 am to 5:00 pm, Saturday 9:00 am to 4:00 pm excluding specific holidays as determined by the center administration. The center will be closed on Thanksgiving Day and Christmas Day.

The center administration has the right to change the holiday schedule. The administration will contact the participant or responsible party to inform them about any holiday schedule changes. The center will be closed during predicted bad weather days or emergency situations (including hurricane and tornado warnings).

The participant shall be dropped off at 8:00 am and picked up at 5:00 pm Monday – Friday and 9:00 am - 5:00 pm on Saturdays. In case of any circumstance(s) causing delay, the executive director of the center must be contacted immediately and notified of the duration of the delay. A late pickup fee of $10.00 every ten minutes after 5:00 pm weekdays, 5:00 pm on Saturdays, may be charged at the administration's discretion.

SERVICES PROVIDED

1. Safe environment for loved ones who are frail, elderly or need general supervision during the day
2. Activities (exercises, group socialization, games, singing, live music, bingo, chair volleyball, crafts, balloon swat, bean bag toss, etc.)
3. Adult day care services
4. Assistance with Self Administration of Medication
5. Nutritious breakfast, lunch, and an afternoon snack
6. Resting rooms for participants to use
7. Haircuts, Manicures, Pedicures, Massage Therapy (additional cost)
8. Personal Care – showers (additional cost)

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AUTHORIZATION FOR EMERGENCY TREATMENT

This gives Next Chapter Assisted Living, LLC authorization to send a participant to the hospital for emergency medical treatment. The participant and/or responsible party authorize Next Chapter Assisted Living, LLC to furnish pertinent medical records to EMS personnel on behalf of the participant during such an emergency.

In case of a medical emergency, such as acute illness or injury, I give authorization to Next Chapter Assisted Living, LLC to send (participant's name) to the nearest hospital emergency room for treatment.

Hospital Preference Request: _____

However, the determination of the hospital to be used may be decided by Next Chapter Assisted Living, LLC staff or by the paramedics of the emergency medical services (EMS) team.

In such an emergency, depending on the time and circumstances, program staff will furnish the participants pertinent medical records to EMS personnel.

In the event of such an emergency, the participant and/or responsible party hereby consents to the release of such information.

_____ _____

Participant or Representative Signature Name

_____ _____

Relationship to Participant Date

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PARTICIPANT COMPLAINTS

All participant complaints will be filed and submitted to the administrative staff using this procedure:

1. Within 24 hours of submission, a verbal response to the complaint will be given.
2. If the response is not satisfactory, then a grievance meeting will take place with participants and administrative staff, which will then lead to resolving the problem to their satisfaction.
3. The executive director needs to fill out the participants' complaint log as soon as possible to resolve the situation.
4. All participant complaints can be sent directly to the executive director's email at dr.tolleyreeves@gmail.com

A response will be given within one business day of complaint if no verbal response was given previously. The participant and/or responsible party have the right to contact the following agencies if the complaint has not been resolved.

Agency for Health Care Administration (AHCA) Complaint Hotline 1-888-419- 456 To Report Abuse, Neglect or Exploitation, please call toll free 1-800-96-ABUSE (1-800-962-2873)

PARTICIPANT'S BILL OF RIGHTS

1. Participant will respect the personal rights and private property of other participants.
2. Participant can retain services from his/her physician and participate in planning their own care.
3. Participant is free from abuse, neglect and exploitation practices in the center.
4. Participant has the right to privacy with treatment and of medical records.
5. The right to not be required to perform duties at the center.
6. The right to communicate privately with persons of the choice and receive assistance in reading and writing correspondence.
7. The right to participate in center activities.
8. The right to not be deprived of constitutional, civil or legal rights due to being admitted to the center.
9. The right to discharge themselves from the facility after meeting qualifications.
10. Participant is assured the opportunity to exercise civil and religious liberties.
11. Participant will not be the object of discrimination.
12. Participant will receive a policies and procedures manual upon admission.
13. Participants may be dismissed for medical reasons or for non-payment.

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DURABLE POWER OF ATTORNEY, RESIDENT OR RESPONSIBLE PARTY

Participant and/or responsible party shall provide sufficient clothing and personal items as needed. Participant and/or responsible party shall provide the program team with current social, medical, health care decision making and other important information regarding the participant.

BILLING CONTACT - REPRESENTATIVE / RESPONSIBLE PARTY

Name		
Relationship (check all that apply) ____ Spouse ____ Healthcare POA ____ Financial POA ____ Legal Guardian ____ Family ____ Friend		
Address		
City	State	Zip
Email		
Home Phone	Work Phone	Cell Phone

ADVANCED DIRECTIVES

I have received information about advanced directives and living wills including my rights to make decisions concerning my general or medical care. I also have received information about the right to accept or refuse any care or treatment and the rights to formulate advanced directives under the state law.

Yes	No	I have an Advance Directive
Yes	No	I have a Living Will
Yes	No	I have a Do Not Resuscitate (DNR) Order
Yes	No	I have a Responsible Party/Power of Attorney

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DISCHARGE POLICIES

The participant and/or responsible party (if applicable) may discharge him/herself from the program. However, the program shall not allow the participant to leave the premises of the program without first contacting the responsible party for discharge instructions or making suitable arrangements for the participant's safety. The center may discharge the participant:

1. When the participant's needs can no longer be met by center, as determined by the sole discretion of the center's administrative staff
2. For medical reasons, including situations in which the participant no longer meets the clinical criteria
3. For non-participation in establishing or updating the plan of care
4. For non-compliance with this agreement or refusal to sign the required admission documentation
5. When the participant's behavior poses a threat to the participant's welfare or the welfare and safety of the other center participants or staff, as determined by the sole discretion of the program staff
6. For nonpayment of incurred charges

TERMINATION OF AGREEMENT

This agreement shall be terminated upon the participant's discharge. However, the participant or responsible party is obligated to pay all unpaid charges, all additional charges and remaining account balance for services rendered up to and including the date of discharge.

TRANSPORTATION AUTHORIZATION

I hereby authorize Next Chapter Assisted Living, LLC to transport the participant to and from the center. I understand that I must advise Next Chapter Assisted Living, LLC if the participant is unable to attend his/her program by contacting the administrative staff 24 hours in advance of the scheduled pick up time. Should there be no responsible party present at the time the participant is brought home. The participant:

____ May enter the home and remain unattended

____ May **NOT** enter the home and remain unattended

If the participant cannot remain unattended and the responsible party is not present when our team attempts to transport them home, then Next Chapter Assisted Living, LLC will transport them back to the center until the responsible party can pick them up. At this point, the responsible party would be responsible for picking the participant up at the center.

If the participant and/or responsible party move to a new address, I understand that the center may not be able to provide transportation depending on the location and proximity to the center.

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CONSENT TO RELEASE INFORMATION

The Participant and/or Responsible Party hereby authorizes and requests any provider of services rendered to release information including diagnosis, treatment, diagnostic testing, prognosis, and recommendations to this facility and or its representatives.

RECORDS RELEASE AUTHORITY

The participant and/or responsible party hereby authorizes and requests any provider of third-party services rendered at the center to release records including diagnosis, treatment, diagnostic testing, prognosis, and recommendations. The participant and/or responsible party understands and freely consents to the release of any and all records generated during residence at the facility and agrees that all records and other documents will remain on the premises and become a part of the permanent record. Copies of records will be provided to the participant and/or responsible party at no cost in response to a verbal or written request. This includes permission to release the following:

1. All records and other information regarding my treatment, services, and care for my impairment(s)
2. Records which may indicate the presence of communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS) and tests for HIV.
3. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and my ability to work.
4. Information created within 12 months after the date this authorization is signed as well as any and all past information.

This authorization allows for the release of information **from:**

1. All medical sources (hospitals, clinic, labs, physicians, psychologists, etc.) including mental health correctional addiction treatment and VA health care facilities.
2. Social workers/rehabilitation counselors
3. Management Companies/ Long Term Care Insurance Companies.
4. Others who may know about my condition (family, neighbors, friends, public officials, etc.)

This authorization allows for the release of information **to:**

1. The department of children and families and adult protective services
2. Agency for Health Care Administration (AHCA) and Medicaid
3. Other professionals such as physicians, therapists, case managers and nurses in the provision of care.

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above. I understand that refusing to sign this agreement does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

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PICTURE AND VIDEO AUTHORIZATION

The participant and/or responsible party authorizes Next Chapter Assisted Living, LLC (A Limited Liability Company), it's assigns, licensees, successors in interest, and legal representatives the irrevocable right to use the participant's picture, portrait, photograph, video and/or any other visual, printed and/or audible media worldwide in all forms and in all manners, for advertising, social media posting, reproduction, sharing, sale, or any other lawful purposes.

The participant and/or responsible party waives any right to inspect or approve the finished version(s), including written copy that may be created and appear in connection therewith. The participant and/or responsible party hereby releases and agrees to hold harmless Next Chapter Assisted Living, LLC, its assigns, licensees, successors in interest, and legal representatives from any liability.

The participant and/or responsible party agrees that Next Chapter Assisted Living, LLC owns the copyright in these photographs and hereby waives any claims they may have based on any usage of photographs or works derived therefrom, including but not limited to claims for either invasion of privacy or libel.

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ADULT DAY SERVICES AGREEMENT

In witness whereof, the undersigned have executed the agreement as of the date listed on the agreement. I met with a representative of Next Chapter Assisted Living, LLC who explained the following procedures to me, including the programs and services provided by the day care center, participant policies and procedures, the Comprehensive Emergency Management Plan, my rights and responsibilities and the grievances, complaints and appeal procedures.

I (member/participant or responsible party) have read, and fully understand the Contract for Adult Day Care. By initialing each page and signing below, I (member/participant or responsible party) am indicating that I agree to honor this contract entirely.

_____	_____	_____
Participant or Responsible Party Name	Signature	Date

_____	_____	_____
Executive Director Name	Signature	Date

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