minds matter

MAGNOLIA MEMORY CARE INC.

APPLICATION PACKET

"Minds Matter,"
a program created to support brain health

Created to provide cognitive stimulation, socialization and support to families caring for their loved ones living with Alzheimer's disease and other related dementias or mild cognitive impairment during the transition and availability of services due to Covid-19.

Magnolia Memory Care, Inc.
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Magnolia Memory Care, Inc. | 501 C3 | EIN# 83 4069643

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MAGNOLIA MEMORY CARE INC.

Mission

To partner with caregivers of loved ones living with Alzheimer's and other kinds of dementia by providing a holistic care model delivering vital resources, support, and services to improve their quality of life.

Vision

To be recognized as the community leader and trusted partner providing compassionate care and spiritual support to those living with Alzheimer's and other kinds of dementia. Focusing on cognitive empowerment and sense of purpose; in an environment that preserves dignity and ***"creates moments of hope."***

Values

Compassion – Be empathetic and caring in everything you do.

Encourage – Give hope. Ensure everyone feels heard and empowered.

Integrity – Be ethical, honest, and transparent, especially when dealing with our vulnerable population.

Purposeful – Caring is an intentional act. Act with intention.

Inclusivity – No one should feel alone. We are in this together, one community.

Servant Leadership – Put the needs of others first. Help others succeed, and we all succeed.

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Part One: Policies and Procedures & Payment Agreement

To provide exceptional service, we ask that the caregiver and participant become familiar with our policies and procedures. You will be contractually bound to adhere to them, as will Magnolia Memory Care, Inc.

Therefore, as a client of Magnolia Memory Care, Inc. I agree to the following:

Magnolia Memory Care, Inc offers the "Minds Matter" program **two (2) days per week, from 10am-2pm** on a fee-for-service basis. The goal is to provide the highest quality, dementia-specific care to your family. Fees are reviewed annually and adjusted as needed. You will be notified in writing about any change to our fees.

Program Operates Two (2) Days Per Week (Wednesday & Friday)

The program will be closed on the following holidays: New Year's Day, Martin Luther King, Presidents' Day, Good Friday, Memorial Day, July 4 th , Labor Day, Thanksgiving Day and Day after Thanksgiving, Christmas Eve, Christmas Day, New Year's Eve.

For clients who have difficulty covering the cost of care due to financial need, Magnolia Memory Care, Inc. has fee-support funds available due to our nonprofit status. Our mission is to fully care for families living with cognitive impairment, regardless of financial resources. Please contact us for more information.

Registration Fee

A non-refundable application/assessment fee of $100 is due at the time of enrollment for new clients. **It may be reassessed should the participant withdraw and decide to reenter the program.**

Fees and Hours of Operation

Two (2) days per week from 10am- 2pm | Wednesday & Friday

$100 per 4-hour program day

Payment for the upcoming month is due by the 25th of the prior month. *For example, payment for April is due by March 25.*

Missed Days

Payment is expected for any scheduled day without a 24-hour notice of cancellation. **As each month is prepaid, credit for these missed days will appear on the next month's statement.**

Elective Withdrawal

You may withdraw your loved one from the program at any time, preferably with a 7-day written notice.

Additional Charges

If your loved one is not picked up after the program day is completed, a designated Magnolia Memory Care, Inc. professional staff person must stay with him/her until the caregiver arrives to ensure his/her safety. Should this time be more than 15 minutes, a $25 fee will be assessed for each 15-minute increment until the participant is safely with a responsible party.

Payment

Payment will be invoiced monthly for the upcoming month. Payment may be made via check or Paypal.

Returned Checks

There is a $35 charge for checks returned for insufficient funds.

Part One: Policies and Procedures & Payment Agreement continued

Please indicate the best days and time for your participant. Based on availability Magnolia Memory Care, Inc. will do its best to accommodate your request.

- ❒ Wednesday
- ❒ Friday
- ❒ Wednesday and Friday

The undersigned understands and agrees to the terms of this contract:

Print Name

Caregiver Signature

Date

Participant Name:

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Scope of Program, Admission & Discharge Policies

Minds Matter is a cognitively stimulating program created to enhance Brain Health. Each 4-hour session will provide cognitive stimulation, socialization, exercise, music, along with a "Brain Healthy" meal. The program will be delivered in a small community setting. Dementia professionals, credentialed in their specialty area of expertise, will work with each participant to create a "person-centered"experience that will improve quality of life and provide respite for the caregiver.

Admission Criteria

1. Free of infectious and/or communicable disease.
2. Must be continent and able to safely self-toilet
3. Ambulatory (*walking either unaided or with walker/cane or short-term wheelchair use which he/she can self-propel.*)
4. Able to feed self.
5. Without aggressive behavior

Magnolia Memory Care, Inc. reserves the right to discharge the participant when any of the above admission criteria are no longer met (*see below*).

Discharge Criteria

1. **Situational:** If your loved one discontinues participation in the program due to hospitalization or a prolonged illness, he/she will be discharged. When you wish to resume the program, the first available opening will be offered to you and your loved one. If hospitalization occurred, discharge paperwork from the hospital is required. Magnolia Memory Care, Inc. reserves the right to re-assess a participant for program readmission viability after hospitalization. The assessment fee may apply.
2. **Disease Progression:** Your loved one has been diagnosed with a progressive disease of dementia. As his/her physical and mental abilities decline, our "Minds Matter" program will no longer be sufficient to meet met participant needs and will require discharge per Discharge criteria, which include:
    a. Participant has an infectious or communicable disease
    b. Participant is unable to safely self-toilet
    c. Participant is not ambulatory (*unable to walk or move self without extensive assistance*)
    d. Participant is unable to self-feed (*has swallowing or mechanical difficulties such as inability to use utensils or move food to his/her mouth*)
    e. Participant exhibits inappropriate behaviors (*wandering, verbal/physical abuse, disrobing, etc.*) that are not managed by medication or other therapies.

MMC, INC reserves the right to notify you in person or in writing, that this professional care determination has been made. Magnolia Memory Care, Inc. will assist you with arranging for alternative care services, as needed.

Scope of Program, Admission & Discharge Policies continued

Your loved one will be able to participate in the program as long as he/she is appropriate for participation. Additionally, Magnolia Memory Care, Inc has the right to immediately discharge, or to not enroll, a participant if:

- ❒ Participant is a threat to themselves, staff, volunteers, and/or any other participant.
- ❒ Participant is an exit-seeker and continually tries to leave the building.
- ❒ Higher-level alternative care arrangements have been made by the family.
- ❒ Participant requires medical/personal care beyond Magnolia Memory Care, Inc.'s stated Purpose an Scope of services.

_____

Print Name

_____ _____

Caregiver Signature Date

_____

Participant Name:

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Participant Rights & Responsibilities

Magnolia Memory Care, Inc. strives to provide the highest quality programming possible, for participants and caregivers. Therefore, every participant and caregiver is entitled to the following rights:

- To be treated as an adult, with consideration, respect, and dignity, including privacy in treatment and in care for personal needs
- To participate in a program of services and activities designed to encourage independence, learning, growth, and awareness of constructive ways to develop one's interests and talents to the extent of the participant's capability
- To self-determination within the day program setting, including the opportunity to participate in developing one's plan for services and any changes therein
- To decide whether to participate in any given activity
- To be involved to the extent possible in program planning and operation
- To refuse participation of an activity and offered another option
- To end participation in the day program at any time
- To be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided
- To a safe, secure, and clean environment
- To confidentiality and the requirement for written consent for release of information to persons not authorized by law to receive it
- To voice grievances without discrimination or reprisal with respect to care or treatment, if applicable, that is (*or is not*) provided
- To be fully informed, as evidenced by written acknowledgment of these rights, of all rules and regulations regarding participant conduct and responsibilities
- To be free from harm, including unnecessary physical restraint, isolation, abuse, or neglect or exploitation.
- To be fully informed, at the time of acceptance into the program, of services and activities available and related charges
- To communicate with others and be understood by them to the extent of the participant's capability
- To be informed of the reason for discharge and the procedures for appealing that decision
- To initiate a complaint and to be informed of the complaint procedure

Magnolia Memory Care, Inc. has the right to expect the participant and caregiver, where applicable, to meet the following responsibilities:

- To be under medical supervision, when needed
- To supply accurate health history information
- To inform professional staff of any changes in health status
- To be available to participate in informational meetings and/or communication regarding the participant
- To be reasonable, considerate, and cooperative with all Magnolia Memory Care, Inc. professional staff and other participants, including not endangering their health and well-being

Responsible Party Signature _____ Date _____

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Part Two: Intake Information

To be completed and returned to Magnolia Memory Care Inc.

PARTICIPANT NAME _____ Social Security # _____ ❒ Male ❒ Female

Address _____ City _____ State _____ Zip _____

Phone _____ Marital Status _____ Race _____

Date of Birth _____ Referred By _____

Eye Color _____ Hair Color _____ Height _____ Weight _____

Distinguishing marks (*glasses, facial hair, etc.*) _____

CAREGIVER NAME _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone (*home*) _____ Phone (*work*) _____ Phone (*cell*) _____

Email _____

Alternate Local Emergency Contacts

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone (*home*) _____ Phone (*other*) _____

Physician Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Billing Information

PARTICIPANT NAME _____

Name _____

Address _____ City _____ State _____ Zip _____

Does the participant have long-term care insurance? ❒ Yes ❒ No
(*Magnolia Memory Care, Inc. may be able to assist with the claim process*)

Part Two: Intake Information continued

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Does your loved one/participant have:

- ❒ Mild Cognitive Impairment
- ❒ Early Stage Alzheimer's
- ❒ Dementia
- ❒ Other (*specify*) _____

Check all that apply:

- ❒ Alzheimer's suspected, but no diagnosis made
- ❒ Diagnosis by family doctor
- ❒ Diagnosis by a specialist
- ❒ Cognitive Testing
- ❒ Other (*specify*) _____

Do you provide most of the care for your loved one? ❒ Yes ❒ No _____

If so, when did you start providing most of the care? Month _____ Year _____

Verification of Medical Power of Attorney and Durable Power of Attorney? ❒ Yes ❒ No

If you are not the primary caregiver, who does provide most of the care and what is his/her relationship to the participant?

_____

Does the participant live in the same household with you/caregiver? ❒ Yes ❒ No _____

If not, with whom does he/she live? _____

About how far away (*in driving time*) do you live from the participant? _____

Which services are you currently using? (*Check all that apply*)

- ❒ Group meals/home delivered meals
- ❒ Transportation services
- ❒ Caregiver support group
- ❒ Paid in-home respite
- ❒ Counseling
- ❒ Legal services
- ❒ Case management
- ❒ Homemaker services
- ❒ Home health services
- ❒ Adult day care
- ❒ Overnight respite in-home
- ❒ Respite in a nursing home
- ❒ Respite in someone else's home
- ❒ Other _____

Are there any services listed that you may be interested in or would like more information about? If yes, please list:

_____

**** Copy of the following information to be reviewed by MMC, Inc before the participant begins the program.

1. Name and Contact information of Primary Care Physician
2. List of medications
3. Most recent History and Physical
4. Written release from Primary Care Physician for Participant to participate in exercise and any restrictions

_____
Participant Name

_____ _____
Responsible Party Signature Date

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Medical Release

To be completed by Physician

Dear Doctor:

Your patient _____ DOB _____ has applied to participate in "Minds Matter" a program created to support brain health. This program will include at least 30 minutes of exercise to include, walking, dancing, and stretching or possibly using light weights or stretching bands.

Please confirm that your patient can be medically cleared to participate in this program:

❒ Yes ❒ No

Any additional Information

_____

_____

_____

_____

Name of Practice _____ Date _____

Doctor's Signature _____ Print Name _____

Sincerely,
Susan Bill, RN, CDP
Founder and Executive Director
Magnolia Memory Care, Inc

PARTICIPANT NAME _____

Date of Birth _____ Today's Date _____

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Social History

Long-term memory often stays intact much longer than short-term memory with cognitive impairment. It is important, therefore, for us to have useful information about your loved one's past so that we may have meaningful dialogue with and about him/her that reveals the richness of his/her life.

Place of birth _____ Location of childhood home _____

Location of adult home(s)_____

Father's name _____ Occupation _____

Mother's name _____ Occupation _____

Siblings _____

Spouse _____ Year Married _____

Children's names _____

Grandchildren's names _____

Great-grandchildren's names _____

High school _____ College _____

Advanced degrees _____ Religious affiliation _____

Ethnicity _____ Military experience _____

Occupation or work experience _____

_____ When retired? _____

Hobbies, interests, activities (*former and present*) _____

_____

Special memories _____

_____

_____

Current daily routine: _____

_____

_____

Pets (*current or childhood*) _____

_____

Any other information about your loved one you feel is important to share? _____

_____

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Releases

Transportation:

At the end of each session my loved one may be released to the care and custody of the following persons or organizations who may be providing transportation:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Photo/Video:

Photographs and videos may be taken during the program. Do you authorize Magnolia Memory Care, Inc. to use and reproduce photographs, files and pictures to circulate and publicize the same by all means, but not limited to, the following: newsletter, television media, print media, brochures, pamphlets, instructional materials, books, clinical materials, website?

❒ Yes ❒ No

Artwork:

A therapeutic art program may be conducted at Magnolia Memory Care, Inc. and projects are completed in many media. Do you authorize exhibition and publication of the art projects completed by your loved one in the program?

❒ Yes ❒ No

_____ _____

Signature of Caregiver/Responsible Party Date

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Emergency Contact Information for Catastrophic Event

Caregiver _____

Address _____ City _____ State _____ Zip _____

Phone (*home*) _____ Phone (*work*) _____ Phone (*cell*) _____

Email _____ Alternate Email _____

Alternate Address _____ City _____ State _____ Zip _____

In the event of a natural disaster or other circumstance that may result in evacuation or relocation, what is the best ***alternate*** way to contact you? _____

_____

Friend or Family Member who could serve as a point of contact when we are directed to evacuate the area?

Name _____ Relationship _____

Phone (*home*) _____ Phone (*work*) _____ Phone (*cell*) _____

Address _____ City _____ State _____ Zip _____

Email _____ Alternate Email _____

In the event the caregiver is injured, incapacitated, or passes away, who will assume care of your participant?

Name _____ Relationship _____

Phone (*home*) _____ Phone (*work*) _____ Phone (*cell*) _____

Address _____ City _____ State _____ Zip _____

Email _____ Alternate Email _____

Please list nearest relative(s):

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

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Authorization for Use or Disclosure of Protected Health Information

- **PARTICIPANT NAME** (First) _____ (Middle)_____ (Last) _____
- Date of Birth _____
- Authorization initiated by _____
  Name (*Participant, POA, Provider or other*)
- Date authorization initiated _____
- Information to be Released:
  - ❒ Authorization for Program Participant's Care Plans
  - ❒ Other (*describe information in detail*): _____

  _____
- Purpose of Disclosure: The reason I am authorizing release is:
  - ❒ My request
  - ❒ To aide in continuum of care
  - ❒ Other (*specify*): _____
- Person(s) Authorized to Make the Disclosure: _____
  Any person or agency involved in the care
- Person(s) Authorized to Receive the Disclosure: _____
  Any person or agency involved in the care
- This Authorization will expire on _____ or upon death.

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.

Signature of the Participant _____

Signature of the Personal Representative _____

Relationship to Client if Personal Representative _____

Date of Signature _____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Inform MMC, Inc. if you do not understand this authorization and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information had already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining long-term insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to Memory Matters and your long-term insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for services at MMC, Inc.
4. Once the information about you leaves this office according to the terms of this authorization, MMC, Inc. has no control over how it may be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.