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.

Magnolia Memory Care, Inc.
2764 Pleasant Road Suite A PMB 676
Fort Mill, SC 29708

704.840.2509
susanbill@magnoliamemorycare.org
www.magnoliamemorycare.org

minds matter
MAGNOLIA MEMORY CARE INC.

Table of Contents & Explanation of Required Signatures

minds matter

MAGNOLIA MEMORY CARE INC.

Mission

To provide valuable education, comprehensive resources, caregiver respite, and spiritual support for those affected by Alzheimer's and related dementias. Through community collaboration, we strive to enhance the quality of life for individuals and families facing these challenges.

Vision

To empower caregivers on the journey with Alzheimer's and related dementias, ensuring they have the support needed to provide the best care.

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.

minds matter
MAGNOLIA MEMORY CARE INC.

Part One: Policies, 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 from 10am-2pm on a fee-for-service basis. Fees are reviewed annually and adjusted as needed. You will be notified in writing about any change to our fees.

Registration Fee

A non-refundable application/assessment fee of $140 is due at the time of submission for new clients. A reassessment fee of $140 will be charged if a participant withdraws and reenters the program.

Fees, Locations and Hours of Operation

- **Pleasant Hill United Methodist Church I** 238 Fort Mill Highway, Fort Mill, SC
  Mondays I 10am–2pm

$140 **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.*

For clients who have difficulty covering the cost of care, please inquire about our scholarship fund. Our mission is to fully care for families living with cognitive impairment, regardless of financial resources.

Missed Days

We understand that situations may arise, but cancellations can significantly impact our operations. Therefore, we do not offer refunds or credits for missed sessions, however we provide credit for up to two missed sessions per year, given that advance notice is provided. We do ask that you notify the Team Lead if you are unable to attend as soon as you know.

Elective Withdrawal

A participant may be withdrawn from the program at any time with a 7-day written notice. Any monies minus the amount for scheduled program days in that period will be refunded.

Part One: Policies, Procedures & Payment Agreement continued

Additional Charges

Late Pick-Up – The safety of each participant is a top priority for all Minds Matter staff. Therefore, a designated Minds Matter staff member must stay with participants until their caregivers arrive to ensure participants' safety. Should the time that the Minds Matter staff has to stay with a participant exceed 15 minutes, a $25 fee will be charged to said participant for each 15-minute increment until the participant is safely with a responsible party.

Insufficient Funds – A $35 fee will be charged for all returned checks due to insufficient funds.

Payment

Payment is invoiced monthly for the upcoming month. Payment may be made via check with no processing fee. Payments made by credit card will have current processing fees applied.

Inclement Weather

Program closing follows the Lancaster County School District inclement weather guidelines. In the case of program cancellation due to inclement weather, caregiver and participants will be notified by 8 am, and a credit for that program day will be applied to the following month's invoice.

The signature below indicates that the signee understands and agrees to the terms of this contract:

Print Name

Caregiver Signature

Date

Participant Name (Printed)

minds matter
MAGNOLIA MEMORY CARE INC.

Scope of Program, Admission & Discharge Policies

Minds Matter is a cognitively stimulating, 'person-centered' program created to enhance brain health, improve participant quality of life, and provide respite for the caregiver. The program is delivered in a small community setting by dementia professionals credentialed in their area of expertise. Each 4-hour session provides cognitive stimulation, socialization, exercise, music, and a "Brain Healthy" meal.

Admission Criteria of Participant

- Be free of infectious and/or communicable diseases
- Be continent and able to safely self-toilet
- Be ambulatory (walking either unaided, with a walker, cane, or short-term wheelchair use which they can self-propel)
- Be able to feed oneself without solid or liquid modifications
- Be without aggressive behavior
- Be free of wanderer or elopement risk

Discharge Criteria

Minds Matter reserves the right to discharge, or not enroll, a participant at their discretion if it is believed to benefit the person and/or the well-being of the program.

Due to the progressive nature of dementia, as a participant's physical and mental abilities decline, the Minds Matter Day program will no longer be sufficient to meet the participant's needs and a discharge will be required.

Discharge Criteria:

- Infectious or communicable disease
- Unable to safely self-toilet
- Not ambulatory (unable to walk or move oneself without extensive assistance)
- Unable to self-feed (has swallowing or mechanical difficulties such as, but not limited to the inability to use utensils or move food to his/her mouth)
- Requires food or liquid modifications
- Exhibits inappropriate behaviors (such as, but not limited to, verbal/physical abuse, disrobing, etc.)
- Is a threat to themselves, staff, volunteers, and/or any other participant
- Is an exit-seeker or elopement risk
- Higher-level alternative care arrangements have been made by the family
- Participant requires medical/personal care beyond Magnolia Memory Care, Inc.'s stated Purpose and Scope of services

The signature below indicates that the signee understands and agrees to the terms of this contract:

Print Name

Caregiver Signature

Date

Participant Name (Printed)

minds matter
MAGNOLIA MEMORY CARE INC.

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 fully informed, at the time of acceptance into the program, of services and activities available and related charges.
- To confidentiality and the requirement for written consent for release of information to persons not authorized by law to receive it.
- To be treated with consideration, respect, and dignity, including privacy in treatment and care for personal needs.
- To participate in a program of services and activities designed to retain and retrain neuro-pathways to the extent of the participant's capability.
- To self-determination within the day program setting, including the right to participate in any given activity.
- To communicate with others and be understood by them to the extent of the participant's ability.
- 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 be free from harm, including unnecessary physical restraint, isolation, abuse, neglect, or exploitation.
- To voice grievances without discrimination or reprisal with respect to care or treatment, if applicable, that is (or is not) provided.
- To initiate a complaint and to be informed of the complaint procedure.
- To be informed of the reason for discharge and the procedures for appealing that decision.
- To end participation in the day program at any time with a preferred 7-day written notice.
- To be fully informed, as evidenced by written acknowledgment of these rights, of all rules and regulations regarding participant conduct and responsibilities.

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 or medications.
- 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.

The signature below indicates that the signee understands and agrees to the terms of this contract:

Responsible Party Signature _____ Date _____

minds matter
MAGNOLIA MEMORY CARE INC.

Medical Release

To be completed by the participant's 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, including walking, dancing, and stretching, and possibly using light weights or stretching bands.

List Primary Diagnosis _____

Any Cardiac History ❒ Yes ❒ No

Any additional Information/Restrictions _____

_____

_____

_____

_____

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

❒ Yes ❒ No

Name of Practice _____ Date _____

Doctor's Signature _____ Print Name _____

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

minds matter
MAGNOLIA MEMORY CARE INC.

Patient Rights and HIPPA 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.

The signature below indicates that the signee understands and agrees to the information listed above:

Responsible Party Signature _____ Date _____

minds matter
MAGNOLIA MEMORY CARE INC.

Authorization for Use or Disclosure of Protected Health Information (HIPPA)

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 _____

minds matter
MAGNOLIA MEMORY CARE INC.

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

_____ _____
Signature of Caregiver/Responsible Party Date

Artwork:

Therapeutic art, utilizing many media, is incorporated into the Minds Matter program at Magnolia Memory Care, Inc. Do you authorize the exhibition and publication of the art projects completed by your loved one?

❒ Yes ❒ No

_____ _____
Signature of Caregiver/Responsible Party Date

minds matter
MAGNOLIA MEMORY CARE INC.

Part Two: Intake Information

To be completed and returned to Magnolia Memory Care Inc.

PARTICIPANT NAME _____ ❒ 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 _____

Local Emergency Contacts

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

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

Billing Information

RESPONSIBLE PARTY _____

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*)

minds matter
MAGNOLIA MEMORY CARE INC.

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. Please fill out the following information regarding the participant's social history.

Place of birth _____ Location of childhood home _____

Location of adult home(s)_____

Father's name _____ Occupation _____

Mother's name _____ Occupation _____

Sibling(s) _____

Spouse(s) _____ Year Married to Each _____

Children's names, genders, and where they live _____

Grandchildren's names, genders, and how often your loved one gets to see them: _____

_____

High school _____ College _____

Advanced degrees _____ Religious affiliation _____

Ethnicity _____ Primary Language _____

Languages Spoken _____ Language Barriers _____

Occupation or work experience _____

_____ When retired _____

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

_____

Special memories _____

_____

_____

Current daily routine: _____

_____

Pets (*current/past*) _____

minds matter
MAGNOLIA MEMORY CARE INC.

Care Team/Medical History

Has loved one or the participant been diagnosed with:

- ❒ Mild Cognitive Impairment
- ❒ Alzheimer's (stage _____)
- ❒ Dementia
- ❒ Other (*specify*) _____
- ❒ There has been no formal diagnosis, but dementia/Alzheimer's is suspected _____

Diagnosis by:

- ❒ Family doctor
- ❒ Primary Care Physician
- ❒ Specialist (neurologist, psycho-neurologist)

Date of diagnosis _____ Date of cognitive testing _____
(*Please provide a copy of the doctor's narrative documentation*)

Does your loved one require someone to provide care? ❒ Yes ❒ No If so, how often? _____

If yes, are you the primary caregiver? ❒ Yes ❒ No

If so, when did you begin providing care? Month _____ Year _____

If someone else provides most of the care for your loved one, who provides it and what is their 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? _____

How far away (*driving time*) do you live from the participant? _____

Which of the following services are being utilized? (*Check all that apply*)

- ❒ Group meals/home-delivered meals
- ❒ Transportation services
- ❒ Caregiver support group
- ❒ Counseling
- ❒ Legal services
- ❒ Case management
- ❒ Homemaker services
- ❒ Home health services
- ❒ Adult day care
- ❒ Paid in-home respite
- ❒ 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:*

_____

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

What is your goal for your loved one as a participant in Minds Matter? _____

_____

minds matter
MAGNOLIA MEMORY CARE INC.

Care Team/Medical History continued

Current Medications

Medication	Dosage	Condition

List of Doctors

Primary Care Physician _____ Phone Number _____

Date of Last Visit _____

Neurologist _____ Phone Number _____

Date of Last Visit _____

Ophthalmologist (Vision) _____ Phone Number _____

Date of Last Visit _____

(*Check all that apply*)

❒ Vision – Good ❒ Vision – Poor ❒ Cataract surgery ❒ Glaucoma ❒ Glasses
❒ Mascular Degeneration ❒ Left ❒ Right ❒ Other _____

Audiologist (Hearing) _____ Phone Number _____

Date of Last Visit _____

(*Check all that apply*)

❒ Hearing – Good ❒ Hearing – Poor ❒ Hearing – Deaf
❒ Hearing Aids ❒ Left ❒ Right ❒ Both

Dentist _____ Phone Number _____

Date of Last Visit _____

(*Check all that apply*)

❒ All natural teeth ❒ Dentures ❒ Partial upper ❒ Partial lower ❒ Implants

Other _____ Phone Number _____

(*Check all that apply*)

❒ Cardiologist ❒ Oncologist ❒ Gastroenterologist

minds matter
MAGNOLIA MEMORY CARE INC.

Home Environment

How many levels/stories does the participant's home have? _____

Is there a ramp into the home? ❒ Yes ❒ No If so, to which door? _____

How many steps up/down to the front door? _____

How many steps up/down from the garage to the house? _____

How many steps up/down to the back door? _____

How many steps up/down between the interior levels of the home? _____

Type of flooring in the home (*Check all that apply*) ❒ Carpet ❒ Tile ❒ Wood ❒ Area rugs

On what level is the participant's bedroom and main bath located? _____

In the participant's main bathroom:

❒ Tub/shower combo Height of tub _____

❒ Grab bars Type _____ ❒ Tub bench Type _____

❒ Walk-in tub

❒ Walk-in shower Height of threshold _____

❒ Grab bars Type _____ ❒ Shower bench/chair Type _____

Height of toilet? _____ Grab bars beside the toilet? ❒ Yes ❒ No Type _____

Does the participant utilize: (*Check all that apply*)

❒ Raised toilet seat ❒ With arms ❒ Without arms

❒ Bedside commode over the toilet ❒ Bedside commode at bedside

Height of bed _____ Adjustable height? ❒ Yes ❒ No

Bedside rail? ❒ Yes ❒ No Type _____

Do they have to walk around the bed to reach the bathroom? ❒ Yes ❒ No

Does your loved one require assistance with any of the following? (*Check all that apply*)

Transferring to the toilet safely? ❒ Yes ❒ No

Managing clothing before/after toileting? ❒ Yes ❒ No

Hygiene after toileting? *For example, wiping.* ❒ Yes ❒ No

Do they wear absorbent briefs? ❒ Yes ❒ No

Please specify assistance provided _____

_____

Transferring to the shower safely? ❒ Yes ❒ No

Home Environment continued

Does your loved one require assistance with any of the following *continued*? (*Check all that apply*)

With bathing/drying? ❒ Yes ❒ No

Please specify assistance provided _____

_____

Dressing? ❒ Yes ❒ No

Please specify assistance provided (*Example: Choosing appropriate clothing, putting on a shirt, fastening buttons, putting on a bra, putting on socks and shoes*)_____

_____

Performing oral hygiene (*brushing teeth, flossing, etc*)? ❒ Yes ❒ No

Please specify assistance provided _____

_____

Sitting/standing from chairs, sofas, or their bed? ❒ Yes ❒ No

Please specify assistance provided _____

_____

Does your loved one utilize any of the following devices? (*Check all that apply*)

❒ Cane ❒ Walker ❒ Rolling Walker ❒ Rollator ❒ Wheelchair ❒ Crutches

History of falls? ❒ Yes ❒ No

If yes, provide date of last fall _____

Does your loved one have: (*Check all that apply*)

Dietary restrictions ❒ Yes ❒ No

If yes, please specify (*Examples: special diet, low sodium, etc*) _____

_____

Food allergies ❒ Yes ❒ No

If yes, please specify _____

_____

Ability to self-feed ❒ Yes ❒ No

Do they require food to be cut up for them? ❒ Yes ❒ No

Do they often cough or clear their throat while eating? ❒ Yes ❒ No

minds matter
MAGNOLIA MEMORY CARE INC.

Behavior Checklist

Please check any of the following behaviors that your loved one exhibits (*Check all that apply*)

- ❒ Wandering
- ❒ Smokes
- ❒ Pacing
- ❒ Threatening
- ❒ Repetitive Stories
- ❒ Clings to You
- ❒ Irritable/Angry
- ❒ Hides Things
- ❒ Bathroom "Accidents"
- ❒ Inappropriate Sexual
- ❒ Disruptive
- ❒ Repetitive Questions
- ❒ Cries Easily
- ❒ Hoarding
- ❒ Depressed
- ❒ Restless/Agitated
- ❒ Suspicious
- ❒ Anxious
- ❒ Trouble with Balance

Behavior

What upsets her/him? _____

What helps her/him calm down? _____

Please elaborate on any behavior issues _____

_____

_____

_____

_____

_____

_____

minds matter
MAGNOLIA MEMORY CARE INC.

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 _____