



## Carson Valley Adult Day Club

1329 Waterloo Lane  
Gardnerville, Nevada 89410  
phone 775-782-5500, ext. 9

### Admission Packet

*Carson Valley Adult Day Club will provide a safe, nurturing and engaging care setting in which older adults, who are living with either cognitive or physical disabilities, or both, will receive individualized social services for some part of their day. While providing these individualized services, we will simultaneously be providing a respite to those caregivers that spend their days caring endlessly for their loved ones.*

*Our program philosophy is to connect multiple generations to the care of an honored individual by providing a safe, nurturing and engaging care setting. Our program utilizes the entire Douglas County Community and Senior Center to fulfill our mission. Our expectation is that while participating in activities within the Douglas County Community and Senior Center, all of their policies and procedures will be followed regarding Code of Conduct and Use of their Facility.*

Thank you for choosing Carson Valley Adult Day Club for your loved one! Please follow the instructions below to start the enrollment process.

#### Instructions:

1. Clients and/or primary caregivers complete that attached forms (excluding the physician examination and TB Test. All information will be kept confidential.
2. Please call 775-782-5500, extension 9 for any assistance.
3. Once completed, contact the Director of the Carson Valley Adult Day Club to schedule your interview and to return your completed packet. Both the client and primary caregiver will need to attend the interview.
4. Complete the physical examination, complete the 2 step TB testing and return documentation to Carson Valley Adult Day Club.
5. Set up your desired participation scheduled with the Carson Valley Adult Day Club.





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### Application for Participation

Please print clearly. All information provided will be used in providing the individualized care plan for the Client.

Client Name: _____	Date: _____		
Preferred Name _____	SSN _____ - _____ - _____	Age: _____	Birth Date: _____
Gender _____	Race: _____	Religious Preference: _____	
Phone: _____	Allergies (List all): _____		
Address: _____			
(Number and Street)		(City)	(State) (Zip Code)
Primary Physician: _____			
(Name)		(City) / (State)	(Phone)

Emergency Contact Name: _____	Relation: _____		
Phone: _____			
Others for emergency contact as needed:			
Name	Relationship	City/State	Phone
_____	_____	_____	_____
_____	_____	_____	_____

Responsible Party: _____	Relation to Client: _____
Bill To Address: _____	
(Number and Street) (City) (State) (Zip Code)	
Physical Address: _____	
(Number and Street) (City) (State) (Zip Code)	
Phone: _____	Email: _____

Can confidential messages be left on your telephone message system? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a Durable Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have Advance Directives in place? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a POLST? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Client Needs

How did you hear about CV Adult Day Club? \_\_\_\_\_

For noticeable improvement, program participation of at least twice per week is strongly recommended.  
Client's preferred schedule for participation:  M  T  W  Th  F

Arriving: \_\_\_\_\_ Departing: \_\_\_\_\_

Please tell us what will help the client the most while participating at CV Adult Day Club?

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Please mark the following that you are unable to perform without assistance?

### Activities of Daily Living

- Eating       Dressing  
 Bathing       Toileting  
 Transferring IN/Out of a Bed/Chair  
 None- I can perform these Activities

### Instrumental Activities of Daily Living

- Preparing Meals       Light Housework  
 Taking Medication       Heavy Housework  
 Managing Money       Using the phone  
 Shopping       Using Transportation  
 None- I can perform these Activities

If needed, I authorized the staff of Carson Valley Adult Day Club to remind me to take prescribed medication while I am attending the program. All self-administered medication will be securely stored and the medication policy will be followed.  Yes  No

Initial: \_\_\_\_\_

\_\_\_\_\_  
*Responsible Party Signature*

\_\_\_\_\_  
*Relationship to Client*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Director CV Adult Day Club*

\_\_\_\_\_  
*Date*



**Vital Signs/Exam:**

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Skin: \_\_\_\_\_

H-ent: \_\_\_\_\_

Cardiac: \_\_\_\_\_

Respiratory: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Genitourinary: \_\_\_\_\_

Musculoskeletal: \_\_\_\_\_

Mental Acuity: \_\_\_\_\_

Bladder Continent  Yes  No

Bowel continent  Yes  No

Catheter  Yes  No

Glasses  Yes  No For? \_\_\_\_\_

Hearing Aid  Yes  No Which ear(s) \_\_\_\_\_

Dentures  Yes  No Partial/Full? \_\_\_\_\_

Oxygen Use  Yes  No Please provide physician order for flow & rate

Fall Risk  Yes  No Number of falls in last 3 months? \_\_\_\_\_

Tobacco Use  Yes  No

**Is the client appropriate to attend Adult Day Services at Carson Valley Adult Day Club?  Yes  No**

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*





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**TB (Tuberculin) Test Informed Consent**

Client Name: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
*(Number and Street) (City) (State) (Zip Code)*

**A two step TB test requires first test injection given and read within 48-72 hours; wait 7-10 days; second step given and read within 48-72 hours. Testing is done annually. Copies will be maintained in client's file.**  
 Your primary physician can complete this test, or you can go to the CVMC Occupational Group.

**If positive (area of swelling or hardness when reviewed by the nurse),** a check x-ray is required initially, then an annual signs and symptoms screening thereafter.

In the past 12 months, do you have or have you developed any of the following:

Cough lasting more than 3 weeks	Yes	No	Unexplained weight loss	Yes	No
Anorexia (loss of appetite)	Yes	No	Fever	Yes	No
Night sweats	Yes	No	Fatigue	Yes	No
Coughing up blood	Yes	No			
Have you had contact with a person that has had active TB that you know of				Yes	No

FIRST STEP					
Date Given	Time Given	Site	Apilsol Lot #	Apilsol Exp Date	RN Nurse Signature
<b>FIRST STEP – Results (within 48 to 72 hours)</b>					
Date Read	Time Read	Results (in mm) Pos/Neg		RN Nurse Signature	

**7 TO 10 DAYS between reading of the first step and injection of the second step**

SECOND STEP					
Date Given	Time Given	Site	Apilsol Lot #	Apilsol Exp Date	RN Nurse Signature
<b>SECOND STEP – Results (within 48 to 72 hours)</b>					
Date Read	Time Read	Results (in mm) Pos/Neg		RN Nurse Signature	

If TB skin test result is **positive**, a chest x-ray and medical evaluation is indicated.

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Name of Professional Reading / Screening this Test                      Signature                      Date





## Social History

Client Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Preferred Pronoun: \_\_\_\_\_

Current Living Situation:  Living alone       Living with Spouse       Living with Caregiver

Place of Birth? \_\_\_\_\_

Places Lived: \_\_\_\_\_

Favorite Place: \_\_\_\_\_

**Marital Status:**     S     M     W     D

Spouse Name: \_\_\_\_\_

Living?     Yes     No      **If no:** Year deceased? \_\_\_\_\_

Anniversary date: \_\_\_\_\_

**Military Service:**     Yes       No

Years: \_\_\_\_\_

Air Force     Army     Marine     Navy     Coast/Nat'l Guard     Reserve

**Religion:** \_\_\_\_\_ **Group:** \_\_\_\_\_

**Smoking?**     Yes     No      **Alcohol?**     Yes     No

**Schooling and Occupations: Please include both past and present:**





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### Client Agreement

To ensure our program fulfills our philosophy to connect multiple generations to the care of an honored senior by providing a safe, nurturing and engaging care setting, and all clients must follow Carson Valley Adult Day Club's policies.

#### Criteria for Admission

Initial: \_\_\_\_\_

The criteria for admission to CV Adult Day Club is listed below. The criteria will be shared with all clients and/or responsible parties during the initial interview, as well as during care plan meeting updates.

Carson Valley Adult Day Club does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status will not be considered in the admission process or treatment following admission.

- Client and/or responsible party will complete admission packet and return to CV Adult Day Club for a scheduled interview. The interview will be interactive between the client and staff during supervised participation in the Club's activities, while the primary caregiver completes social history, medical history, and admission paperwork with the Director. The individualized care plan will be created during this time for the client. Interview should last no longer than 1 hour.
- Client and/or responsible party will provide CV Adult Day Club with the results of a physical examination conducted by a physician, physician assistant, or advance practice registered nurse along with a summary of their medical history within the preceding 6 months. The physician will indicate that the Club is an appropriate setting for the client and indicate any special dietary requirements or reasonable accommodations.
- Each client will designate a primary physician to be called in case of change of condition. CV Adult Day Club's policy is to call 911 in case of an emergency. Our staff is not able to diagnose or care for untreated injuries.
- Client will complete the required 2-step TB test prior to admission, providing documentation to the CV Adult Day Club. Client will follow TB guidelines and be tested every year hereafter.
- Client and/or primary caregiver will notify CV Adult Day Club if there is any change in medications or physician orders.
- Client should require minimal assistance (1 person) for bowel and bladder management, along with hygiene or transferring needs. Clients needing more assistance will be reviewed on a case by case basis.

- Client will not require 1 on 1 supervision for the entire time they are attending CV Adult Day Club.
- Client will not attend the CV Adult Day Club if they have an acute illness. The illness policy will be followed to ensure the well-being of the other clients and staff.
- Client should not cause harm, either physical or emotional, to themselves or others. Behaviors such as the following will be documented and if possible, interventions will be implemented with the help of family and health care providers if necessary.
  - Causing physical harm to self or others
  - Wandering that cannot be redirected
  - Physical health requiring 1 on 1 supervision
  - Constant, disruptive behavior that results in other clients' agitation
  - Inability to attend or participate in any of the activities
- Clients must be able to communicate their needs to staff, verbally or written, or through body language. Care plans will be designed to acknowledge the form of communication for each client.
- Client cannot require any form of restraint as CV Adult Day Club is not able to use restraint, either physical or medicinal.
- Client and/or primary caregiver will arrange transportation to and from the CV Adult Day Club.
- Client must be able to self-administer any medication with minimal reminders. Client and/or primary caregiver will provide physician orders, medications in original packaging, and correct dosage for day. CV Adult Day Club will provide a secure location for all self-administered medications.
- Clients will be referred to other programs if their needs cannot be met by CV Adult Day Club.

## **Program Policy**

**Initial:** \_\_\_\_\_

Our program policy will be shared with all clients and/or responsible parties during the initial interview, as well as during care plan meeting updates.

To be successful, our program is based on mutual respect, cooperation, confidentiality, and the safety of our clients, staff, and volunteers. Any violation of the program expectations will lead to discharge and referral to another program for the client.

The following are expected:

- Clients and/or the responsible party will sign in upon arrival to the CV Adult Day Club. All medication will be given to staff to document and secure in a locked box.
- Additional clothing will be provided by the family for the client, labeled with their name, and stored in their designated area by staff. If there comes a need for changing, clothing will be appropriately laundered (given enough time) and returned by the end of the day to the client and/or responsible party.
- Client and/or their responsible party will provide their own disposables and hygiene items needed for the day. CV Adult Day Club will provide storage for these items.



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- Clients will leave all valuables and money at home. CV Adult Day club will not be responsible for any valuables or money left in the possession of the client while they are attending.
- Clients will carry appropriate identification with them when attending.
- CV Adult Day Club is a smoke free environment. Clients and/or their responsible party will make the staff aware if they need accommodations.
- CV Adult Day Club will provide a monthly calendar to each client notifying them of activities scheduled. Activities will be scheduled throughout the community center, utilizing staff and volunteers for oversight/supervision.
- CV Adult Day Club will provide the noon hour lunch, served in the Douglas County Senior Center dining room. Accommodations can be made to have lunch in the CV Adult Day Club room.
- CV Adult Day Club has a designated area for resting. The Den is available to all clients, with the expectation that the clients use the Den as a temporary quiet place.
- CV Adult Day Club agrees to exercise the best care for our clients; however we are in no sense an insurer of the client's safety or welfare and assume no liability as such.

### **Medication Policy**

**Initial:** \_\_\_\_\_

CV Adult Day Club can provide medication reminders to clients. We are not able to administer medication of any kind. For any clients that are unable to self-administer, referral will be made to another program or alter times of attendance as to not to occur during medication time.

As clients arrive each scheduled day, their prescribed medication will be handed to the staff, using the outline below. The staff will document all medication and assign a numbered lock box to the client. The client will be given the only key to that lock box. That box will then be secured in a designated, locked spot, accessible only by staff

Using the physician orders, staff will remind clients of the need to self-administer their medication at the appropriate time. The client will be provided a designated spot in which to take medications. Staff will document that medication was or was not taken and any reason for missed dosages.

Upon leaving, the staff will return the medication to the client and/or responsible party and document as such.

In order to provide medication reminders, clients must follow these guidelines:

- Current physician orders must be provided to CV Adult Day Club.
- Medications must be given to staff upon arrival to be put in secure box. No medication (including over the counter) may be with the client at CV Adult Day Club. Medications must arrive in original containers with current pharmacy labels.
- CV Adult Day Club must have documentation of all medications the client is taking.
- CV Adult Day Club must be notified of any changes to physician orders upon arrival for the day.

## **Smoking Policy**

**Initial:** \_\_\_\_\_

Clients requesting to smoke while attending the Club will undergo a Smoking Risk Assessment at time of assessment, and each time a care plan is completed. Clients must be able to safely perform all actions of smoking, from appropriately holding their lighter/cigarettes to the disposal of their ashes and remains of the cigarette in appropriate receptacles with minimal cueing.

The family and client will provide all smoking materials, along with appropriate outerwear for the weather conditions. If client is unable to dress appropriately, maintain their smoking items or smoke safely, family will be notified that smoking will not be allowed while attending the Club.

Staff will accompany clients to the designated smoking area of the Community Center. Staff will provide minimal cueing to ensure safety of clients and property.

In the event of inclement weather such as snow/ice storms, heavy rains or wind, the Director will determine the safety of clients and staff going outside. If deemed not safe, family and clients will be notified that smoking will not be permitted for that period of time. In the event of the Air Quality Index (AQI) measurement category being “Unhealthy for Sensitive Groups,” “Unhealthy”, “Very Unhealthy” or “Hazardous”, the Director will discuss risks and safety with family and clients for going outside. The Director will inform family and clients if determined it is unsafe to go outside due to the AQI.

## **Care Plan Policy**

**Initial:** \_\_\_\_\_

Based on the information provided in the admission packet, and during the on-site interview, an individualized care plan will be created for each client. The client, responsible party, and Director will review and approve the care plan prior to the client starting the program. After 30 days, the care plan will be reviewed with the staff, client, and responsible party to update as needed based on participation at CV Adult Day Club. The care plan will contain all areas of Activities of Daily Living (toileting, showering, hygiene, dressing, and social) and the social activities of interest to the client.)

Care plans will be reviewed with the staff, client, and caregiver in the event of a change in condition, or yearly, whichever is sooner. Current care plans will be available to staff for review at all times in a secure location. Clients and responsible parties may ask to review their care plans at any time. Care plans that have been update, will be stored in the client’s confidential file, located in the Director’s office.





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### Illness Policy

Initial: \_\_\_\_\_

To ensure the safety and well-being of our clients and staff, clients are not permitted to attend CV Adult Day Club if they have had a fever in excess of 100°F, or uncontrollable diarrhea or vomiting in the previous 48 hours. Caregivers will provide communication to CV Adult Day Club if this occurring. Clients will be required to bring a physician's note clearing them to attend the program if their illness was communicable or contagious.

If a client is unable to attend a scheduled day, a 24 hour notice is required. Program credit will be issued with this advance notice. If there is a no call, no show, there will be no program credit issued. Multiple no call no show absences will lead to the suspension of participation of the program. The Director will meet with client and/or responsible party to discuss obstacles of attendance and determine the best course of action. The documentation of this meeting will be kept with the client's confidential file.

In the event of an emergency, or family crisis with notice of missing a scheduled day of less than 24 hours, program credit will be issued based on the Director's discretion. Events for which a doctor's note is provided, uncontrollable behavior of client prior to arriving, an incident with a family member causing an emergency room visit are examples in which program credit will be issued.

### Billing Policy

Initial: \_\_\_\_\_

Payment for attending the program is due prior to arriving on the scheduled day. Payments can be made by cash, check, or money order. If the client is utilizing a grant, VA payment, or long term care insurance, CV Adult Day Club will not be responsible in billing these agencies. It is the responsibility of the client and/or responsible party to submit claims to these agencies for reimbursement.

If the client schedules and prepays for 30 days, at no fewer than 3 partial or full days per week there will be a 10% discount off the entire month cost when paid by the 3<sup>rd</sup> Wednesday of the previous month (this will be noted on the monthly calendar as Discount Prepayment Wednesday).

All Sign In/Out logs will be filed at the end of each month in the Invoice Binder as documentation of program attendance.

## **Fees Schedule**

**Initial:** \_\_\_\_\_

Hours of operation are:

Monday through Friday = 7:00 am – 6:00 pm (excluding holidays)

Meals and nutritious snacks are provided for each client.

Full Day = 5 hours or more of participation = \$70/day

Partial Day = Less than 5 hours of participation = \$45/day

Shower/grooming = \$15/scheduled

Discount available- Schedule and prepay for 30 days, no less than 3 days per week (either partial or full) to receive 10% off entire month.

Our staffing schedule and dietary supplies are based on scheduled attendance. For this reason we request a call by 9:00 am if a client will not be attending that day. No call no show by 10:00 am on the day scheduled will incur a \$15 charge. Two or more no call no shows in a month can lead to suspension of participation in the program.

Any returned payments will incur a \$40 charge.

## **Holiday Schedule (dates the CV Adult Day Club are Closed) Initial:** \_\_\_\_\_

New Year's Day

Martin Luther King, Jr. Day (3<sup>rd</sup> Monday in January)

President's Day (3<sup>rd</sup> Monday in February)

Memorial Day (Last Monday in May)

Independence Day (July 4<sup>th</sup>)

Labor Day (First Monday in September)

Nevada Day (Last Friday in October)

Veterans Day (November 11<sup>th</sup>)

Thanksgiving Day (4<sup>th</sup> Thursday in November)

Family Day (Day after Thanksgiving)

Christmas (December 25<sup>th</sup>)

In the case of inclement weather, or a community event, that closes the Douglas County Community and Senior Center, the CV Adult Day Club will also be closed. In these cases, a staff member will contact the client and/or responsible party via phone.



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Initial: \_\_\_\_\_

Clients and/or responsibly parties have the right to file a complaint concerning the program or its participants, volunteers, or staff. The process is as follows:

1. Complaints must be submitted in writing to the Director of CV Adult Day Club.
2. The Director will review the complaint within 5 business days of receipt to determine whether a violation of the code of conduct has occurred.
  - a. If the subject of the complaint is not a violation of the code of conduct, the Director shall attempt to resolve the problem informally.
    - i. The Director will meet with the parties involved within 10 business days of reviewing the complaint to attempt to achieve an informal resolution.
    - ii. If the parties are not satisfied with the informal resolution, the parties must serve a request in writing to the Director that the complaint be appealed to the Douglas County Manager of Social Services for review. The Manager must review the complaint within 15 days of the written request, and must provide a written response to the parties within 20 business days of the written request.
    - iii. All decisions by the Manager are final.
  - b. If the complaint is against a staff member, the Director must follow the disciplinary procedures set forth in the Douglas County Code and/or the Douglas County Employees Association Bargaining Agreement. As personnel related matters are confidential, the complaining party does not have a right to know the outcome of any discipline. The complaining party does not have the right to appeal any decision of the Director with respect to an employee.
  - c. If the complaint is based upon a violation of the code of conduct, the Director shall follow the procedures for discipline.

## Grievance

Initial: \_\_\_\_\_

Clients and/or responsibly parties have the right to file an appeal with a fair and equitable review of decisions. The process is as follows for an appeal of Denial, Suspension, or Termination from the CV Adult Day Club program:

1. The client and/or responsible party may request, in writing, a review by the Douglas County Manager of Social Services within seven (7) days after being provided the notice.
2. Upon receipt of the appeal, the Director shall forward a copy of the information used to make the determination, a copy of the determination, and a copy of the appeal to the Manager of Social Services.
3. The Manager of Social Services (or their designee) shall review the information no later than ten (10) calendar days following the receipt of this notice. The Manager of Social Services may meet with the parties if he or she feels it is warranted.
4. The Manager of Social Services shall provide a decision in writing to the Director and participant no later than twenty (20) calendar days from the date of the notice.

If the participant is not satisfied with the decision of the Manager of Social Services, the participant may appeal the decision to the Community Services Divisional Director.





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### Client Rights

1. The right to be treated as an adult, with consideration, respect, and dignity, including privacy in treatment and in care for personal needs.
2. The right 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.
3. The right to self-determination within the day services setting, including the opportunity to participate in developing one's plan for services and changes thereafter; decide whether or not to participate in any given activity; be involved to the extent possible in program planning and operation; refuse treatment and be informed of the consequences of such refusal; end participation in the adult day program at any time.
4. The right to a thorough initial assessment and the development of a plan of care.
5. The right to be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided.
6. The right to a safe, secure, and clean environment.
7. The right to receive nourishment and assistance with meals as necessary to maximize functional abilities and quality of life.
8. The right to confidentiality and the requirement for written consent for release of information to persons not authorized under law to receive it.
9. The right to voice grievances without discrimination or reprisal with respect to care or treatment that is provided.
10. The right to be fully informed, as evidenced by the client's written acknowledgement of these rights, of all rules and regulations regarding client conduct and responsibilities.
11. The right to be free from harm, including unnecessary physical or chemical restraint, isolation, excessive medication, abuse, or neglect.
12. The right to be fully informed, at the time of acceptance into the program, of services and activities available to related charges.
13. The right to communicate with others and be understood by them to the extent of the client's capability.

Client Name: \_\_\_\_\_

Initial: \_\_\_\_\_





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**Photography, Video and/or Audio Taping Consent**

Client Name: \_\_\_\_\_

- I authorize Carson Valley Adult Day Club to photograph, video and/or audio tape client to be used for clinical purposes.
- I **do not** authorize Carson Valley Adult Day Club to photograph, video and/or audio tape client to be used for clinical purposes.
- I authorize Carson Valley Adult Day Club to photograph, video and/or audio tape client to be used for marketing purposes and/or their Facebook page.
- I **do not** authorize Carson Valley Adult Day Club to photograph, video and/or audio tape client to be used for marketing purposes and/or their Facebook page.

\*\*\* Please be advised that Carson Valley Adult Day Club is under 24 hour video surveillance.

\_\_\_\_\_  
*Responsible Party Signature*

\_\_\_\_\_  
*Relationship to Client*

\_\_\_\_\_  
*Date*







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### Authorization to Release Records

This is to certify that permission is hereby granted to release information as follows:

Information to be released for \_\_\_\_\_  
*Name of Client* *Birth Date*

Information to be released by \_\_\_\_\_  
*Name of physician, clinic, agency, etc.*

Information to be released to **Carson Valley Adult Day Club.**

Reason \_\_\_\_\_

The following information may be released for the purpose of treatment and care:

- Complete Health Care Record(s)
  - History and Physical Examination
- Discharge Summary
- Care Plans
- Progress Notes
- Pathology Reports
- Medical/Treatment Records
- Consultation Reports
- Radiology Records
- Emergency Care Records
- Transcribed Reports
- Other: \_\_\_\_\_
- Nurses' Notes

I understand that this will include information relating to:

- Psychiatric/Psychological Initial: \_\_\_\_\_
- HIV Initial: \_\_\_\_\_
- Drug/Alcohol Dependency Initial: \_\_\_\_\_

1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked in writing. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of the authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by these federal regulations.
5. A copy of this authorization is as effective as the original.

\_\_\_\_\_  
*Responsible Party* *Relationship to Client* *Date*





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**CONSENT TO USE OR DISCLOSE HEALTH INFORMATION**

I authorize Douglas County to use and disclose my medical records for the purposes of Treatment, Payment and Health Care Operations.

**Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

**Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

**Health Care Operations** includes the necessary administrative and business functions of our office.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Douglas County's "Notice Of Privacy Practices" for additional information about the use and disclosure of the information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date in the upper right hand corner of the Notice. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Douglas County has already used or disclosed the information in reliance on this Consent and to examine the County's Notice of Privacy Practices.

\_\_\_\_\_  
*Signature of Client/Person Authorized by Law*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Client/Person Authorized by Law*

\_\_\_\_\_  
*Date*





Carson Valley Adult Day Club

1329 Waterloo Lane  
Gardnerville, Nevada 89410  
phone 775-782-5500, ext. 9

## NOTICE OF PRIVACY PRACTICES OF DOUGLAS COUNTY

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

You are receiving this notice in accordance with the Health Information Portability and Accountability Act (HIPAA), a federal law which governs the privacy of your health information.

### **WHO WILL FOLLOW THIS NOTICE**

This notice describes the information privacy practices followed by Douglas County Social Services.

### **YOUR HEALTH INFORMATION**

This notice applies to the information and records we have about your health, health status, and the health care and services you may receive from Social Services.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment** Although the County may not provide direct treatment to you, which your physicians or dentists and their staff do, we are including these next three paragraphs for your general information on the functioning of HIPAA. They may use health information about you to provide you with medical treatment or services. They may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in their offices may share information about you and disclose information to people who do not work in the office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

**For Payment** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

**For Health Care Operations** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

**Appointment Reminders** We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

**Treatment Alternatives** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Products and Services** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

## **SPECIAL SITUATIONS**

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

**To Avert a Serious Threat to Health or Safety** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required By Law** We will disclose health information about you when required to do so by federal, state or local law.

**Research** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

**Organ and Tissue Donation** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

**Military, Veterans, National Security and Intelligence** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.



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**Health Oversight Activities** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

**Law Enforcement** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Coroners, Medical Examiners and Funeral Directors** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Information Not Personally Identifiable** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Family and Friends** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

### **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

### **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy** You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Social Services in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

**Right to Amend** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to Social Services. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

**Right to an Accounting of Disclosures** You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to Social Services. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

**We are Not Required to Agree to Your Request** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request For Restriction On Use/Disclosure Of Medical Information to Social Services.

**Right to Request Confidential Communications** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication to Social Services. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Social Services.





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### CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Social Services. You will not be penalized for filing a complaint.





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## Financial Assistance Resources

### Alzheimer's Grant

Charae Wamsley 775-786- 8061, ext 1230  
chwamsley@alz.org

- <http://www.alz.org/>
- \$250 per quarter
- Diagnosed with memory disorder
- Caregiver must live with care recipient

Douglas County Social Services  
775-782-9825

- Be a resident of Douglas County.
- To provide income and asset information

### Seniors in Service Grant

Kim Fontz 775-358- 2322

<http://nevadaadrc.com/resources/learn-about/item/683>

- Provides \$1,000 per year
- Must be 60+ years old
- No diagnosis of memory disorder





