Dear Family Member,

Thank you for your interest in Alzheimer's Services Center. We offer the following services: daycare, respite, and/or outreach program.

We have enclosed a brochure describing our services. Our core foundation is built on the commitment to provide quality services to our clients. We provide an ongoing commitment to giving our clients the highest quality of care and support to their caregivers. We are available to answer any additional questions you may have about our program. You may contact us at the above telephone number during normal business hours (7:30 am to 4:30 pm) Monday through Friday.

We have also enclosed forms that would be helpful for us to provide information. Please follow these procedures below:

- Complete the Client Information Form
- Have your loved one's Primary Care Physician complete the Medical Examination Form
- Current T.B. test results or a chest x-ray report must be included
- Affidavit verifying status of citizenship which will need to be notarized
- Proof of COVID Vaccinations/Booster

Once you have completed and returned these forms back to us, our intake nurse will call you to set up an appointment time for an admission evaluation. Please plan for two (2) hour process. Our intake nurse will complete an evaluation along with our Social Worker to determine if our program is appropriate for your loved one. You will also need to bring insurance cards and all medications in their bottles.

You may contact our office to schedule an appointment regarding admission to the Center. We look forward to hearing from you soon.

With kindest regards,

ASC

ALZHEIMER'S SERVICES CENTER
7251 Mt. ZION CIRCLE
MORROW, GA 30620-3309
770 603-4090 Office 678 519-9863 Fax
info@ascga.org

Frequently Asked Questions

Who We Are: ASC Mission Statement: The Alzheimer's Services Center's mission is to enhance and prolong the highest quality of life possible for persons with Alzheimer's disease and other related disorders and for their families.

Alzheimer's SERVICES Center offers a unique combination of premier programs and services for clients who have Alzheimer's and other related disorders.

Our typical day includes activities such as bingo, seated exercises, brain stimulation activities, crafts, computer, and group activities designed for our participants' likes and specific care plan.

Medication management is available with a physician's order.

Funding assistance for Adult Day Care is available, but limited at the Alzheimer's Services Center. Please inquire during a tour of our facility.

*Tours are available on a walk in basis during the hours of 9:00 a.m. – 4:00 p.m.

How do I know if my loved one needs an adult day health program?

If your loved one is at home during the day and is in need of socialization, stimulation and medical oversight an adult day program will be a good alternative in their care.

What do I need to do to introduce my loved one to the concept of adult day health?

After the completion of a medical assessment and determination of daily rate, we can provide a '4' hours trail to introduce your loved one to the program, which will allow us to get to know them.

How much is the program per day?

The program daily rate goes by a sliding scale fee with a minimum of $40.00 per day. Adult Day Care program such as ours offers the lowest cost alternative of the care of your loved one.

How do I know how much we will pay per day?

The program daily rate will be determined based on the clients' monthly income.

What form of payments does the center accept?

The center accepts various forms of payments including Private Pay and Medicaid (**CCSP & Source**). For private pay clients' payment can be made on a weekly or monthly basis.

What are our hours and how many hours can my loved one be at the center?

The Center is open Monday through Friday from 7:30 a.m. until 4:30 p.m. To get the most out of the program our full day curriculum is 55 or more hours, but you can use any hours needed between 7:30 a.m. until 4:30 p.m.

Is there a minimum amount of days my loved one must attend?

A 2-day minimum per week is required. This enables our staff to get to know your loved one and their needs. It also provides consistency and structure in your loved ones' daily schedule.

Do I need to bring lunch for my loved one to attend?

Our program includes breakfast, a hot lunch and an afternoon snack.

Does your program have outings?

Occasionally the center offers outings for clients in the first group. The cost of specialized activities such as outings is based on the cost to cover the activity.

How long is the contract?

A deposit is required upon enrollment along with a medical questionnaire and TB test that can either be administered by our Nurse Practitioner or your loved one's primary physician. A two-week notice is required for discharge to receive a refund of this deposit.

CLIENT EMERGENCY CONTACT FORM

EMERGENCY CONTACTS:

NAME: _____
RELATIONSHIP: _____ HOME
TELEPHONE: _____ WORK
TELEPHONE: _____ CELL
TELEPHONE: _____

NAME: _____
RELATIONSHIP: _____ HOME
TELEPHONE: _____ WORK
TELEPHONE: _____ CELL
TELEPHONE: _____

NAME: _____
RELATIONSHIP: _____ HOME
TELEPHONE: _____ WORK
TELEPHONE: _____ CELL
TELEPHONE: _____

AUTHORIZED PERSON TO PICK UP CLIENT:

NAME: _____

NAME: _____

_____ _____
CAREGIVER SIGNATURE DATE

ATTENTION CAREGIVERS:

Please be advised that if the client is hospitalized or has any type of medical procedure, the Center must have the physician's medical release in order for the client to return to the Center

_____ _____
CAREGIVER SIGNATURE DATE

CLIENT INFORMATION & EMERGENCY MEDICAL FORM

Participant's Name: _____ D.O.B. _____ Age_____

Address: _____ M ☐ F ☐

City:_____ County:_____ Zip:_____

Caregiver's Name: _____ Relationship: _____

Caregiver's D.O.B. _____ SS#_____

Address: _____

City: _____ County: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____ E-Mail_____

EMERGENCY CONTACT IF CAREGIVER IS UNAVAILABLE

Name: _____ Relationship: _____

Address:_____ City:_____

County:_____ Zip:_____

Home Phone: _____ Work: _____ Cell: _____

In the event of my unavailability, I authorize the official staff of the Alzheimer's Services Center to act for me in giving consent for medical treatment if necessary for: _____

Medicare Number :_____ Medicaid Number: _____ SS#_____

Other:_____

Primary Physician:_____ Office Phone:_____

Hospital:_____ Phone:_____

Ambulance Service:_____ Phone:_____

Allergies:_____

Diagnosis of Alzheimer's Disease ☐ **Yes** ☐ **No** **Date of DX:** _____

Pertinent Medical History: _____

Special Needs: _____

Advance Directive Information: _____

In case of Medical Emergency, I agree for 911to be notified for possible transport to nearest hospital
If not, who should be contacted?_____Current Medications:_____

_____ (I agree to assume responsibility for **all expenses involved in receiving prompt medical care.)**

How did you hear about our Center? _____

Signature of Caregiver/Guardian: _____ **Date:** _____

7251 Mount Zion Circle
Morrow, GA 30260
(O) 770-603-4090 (F) 678-519-9863
www.ascga.org

MEDICAL EXAMINATION

(To be completed by Physician)

Date: ____/____/____

Name of Patient_____ Date of Birth: ____/____/____

Address _____ City _____ Zip _____

Home Phone: _____ Cell/Work: _____

Diagnosis of Alzheimer's Disease Yes ☐ No ☐ Date of Diagnosis: ____/____/____

Other Diagnosis, Medical Problems or Impairments?

_____

_____

Vital Signs BP: _____ Heart Rate _____ Respiration _____

Has Patient been given Mini Mental Status Test? _____ Total Score _____

Date of Last Examination _____

STANDING ORDERS

The following orders once signed by the physician are effective for one (1) year and must be updated yearly.

1. Tylenol 325 mg. 1 or 2 tablets every 4 hours as needed for pain or fever
   Physician Initial

Yes	No

2. May check blood sugar with finger stick testing unit as needed for signs/symptoms of hyper/hypo-glycemia.
   Physician Initial

Yes	No

3. Minor wound care as needed-cleanse with peroxide, apply triple antibiotic and dressing.
   Physician Initial

Yes	No

4. Tums 1 or 2 tablets every 4 hours as needed for indigestion/heartburn
   Physician Initial

Yes	No

4. Maalox 30cc every 4 hours as needed for stomach upset

Physician Initial	Yes	No

MEDICAL CERTIFICATION SIGNATURE REQUIRED

Adult Day Care living facilities/personal care homes ARE NOT permitted under the law to provide medical, skilled nursing or psychiatric care. In your professional opinion, can this patient's needs be safely met in an assisted living facility/personal care home? YES: _____ NO_____

COMMENTS:_____

_____

_____

_____

_____

SIGNATURE OF PHYSICIAN, PA OR NP	**DATE**
PRINTED NAME OF PHYSICIAN, PA OR NP	**GEORGIA LICENSE #**

ADDRESS OF PHYSICIN, PA OR NP		
CITY	**STATE**	**ZIP CODE**

TELEPHONE	**FAX**

Tuberculosis Risk Appraisal Questionnaire (TB-RAQ)

Name of Client/Staff: _____

Date: _____

Are you experiencing any of the following symptoms?

	Yes	No
1. Persistent cough lasting for 2 weeks or more?		
2. Change in cough or coughing up blood?		
3. Fever or night sweats for more than 1 week?		
4. Loss of appetite or unexplained weight loss?		
5. Chronic fatigue with any of the above symptoms?		

If yes, explain. Includes dates._____

Date of positive PPD: _____ Reaction in mm: _____

Date of last negative PPD: _____ Date referred for evaluation: _____

Date of chest x-ray: _____ Results: _____

I realize that I must report any signs and symptoms of TB that I may develop, especially a persistent cough lasting 2 weeks or more in the presence of any other signs and symptoms of TB.

_____ Date: _____

(Signature)

Tuberculin Skin Test PPD Record

Name of Client/Staff: _____

Date Administered		
PPD Manufacturer		
Expiration Date and Lot#		
Dose Administered		
Site		
Administered By (Full Name and Title)		
Date Result Read		
Results (in exact mm)		
Read By (Full Name and Title)		
Referred for follow-up?		

Skin test must be checked in 48-72 hours for any induration or raised area. If
Distinctly palpable induration is present, measure in millimeters at widest
Area perpendicular to long axis of the forearm and document. Do not
Measure erythema or redness of the skin.

ADMINISTRATIVE FEE

An Administrative Fee of $25.00 will be assessed during the intake process. Payment is expected in advance, either the first week of the month or the first day of each week that the client is attending. An administrative fee of $25.00 will be initiated on the 5th day of the following month, due to late payments. We accept checks and money orders payable to: Alzheimer's Services Center or ASC. There will be a charge of $35.00 for NSF checks. Payment is accepted at the Center office, Tuesday through Thursday from 7:45 a.m. to 4:00 p.m., or mailed to:

Alzheimer's Services Center
7251 Mt. Zion Circle
Morrow, GA 30260

Affidavit Verifying Status of Benefit Applicant

Pursuant to the Georgia Security and Immigration Compliance Act (O.C.G.A 50-36-1), effective July 1, 2007, every agency in _____ county providing public benefits through state or federal program is responsible for determining the immigration status of citizen applicants for said benefits.

By executing this affidavit under oath, as an applicant for benefits, I am stating the following with respect to my application for benefits from _____:

_____ I am a United States citizen 18 years of age or older;

_____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act, 18 years of age or older and lawfully present in the United States.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of Code Section 16-10-20 of the Official Code of Georgia.

_____
Printed Name

_____ _____
Signature of Applicant Date Date

Subscribed and sworn before me on this

the _____ Day of _____, 20 _____.

_____
Notary Public My Commission Expires:

_____
My Commission Expires: