HAPPY HEALTH CENTER

Consent to Use & Disclose Protected Health Information for Treatment, Payment, or Healthcare Operations

HIPPA

I, _____ hereby authorize the disclosure of information from my health records that is requested by Happy Health Center Adult Day Health Taunton located at 174 Broadway Rear Taunton, MA 02780.

This authorization is valid for the release of information on the date included in this authorization and thereafter.

I understand that the Center maintain, use, and disclose personal health information in order to provide for my care and treatment, to arrange for billing and payment for my care and carry out general management and operations of the facility such as quality review. In addition, I understand that I have the following rights:

The right to request restrictions on how protected health information about me is used or disclosed for treatment, payment, or health care operations. The facility is not required to agree to my request, but if it does, it will be bound by its agreement.

The right to revoke this Consent, in writing, except to the extent the facility has acted in reliance on the Consent. The right to receive a copy of this Consent form.

I consent to the use and disclosure by Happy Senior Daycare Inc., dba/Happy Health Center and its agents or representatives of all my personal health information for purposes of treatment, payment, and health care operations.

By signing below, I acknowledge that I have read and understand this Consent form.

Participant's Name: _____ Date of Birth: _____

Participant's Address: _____

Phone: _____

Participant's Signature: _____ Date: _____

If signed by the Participant's Representative, please print name, and describe relationship toparticipant:

_____ _____

Name of Authorized Representative / Relationship Date

HAPPY HEALTH CENTER – ADULT DAY HEALTH

174 BROADWAY REAR · TAUNTON, MA 02780 · (508) 258-7500 · FAX (508) 258-7501

PARTICIPANT ENROLLMENT APPLICATION

REFERRED BY: _____ COMPANY: _____ REFERAL DATE: _____

REFERAL PHONE: _____ EMAIL: _____

Days of the week interested in attending the program --- ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Transportation ☐ Yes ☐ No ---- ☐ One Way ☐ Both Ways ----- ☐ *Wheelchair*

NAME:	DOB:	AGE:
ADDRESS:		
CITY:	STATE:	ZIP:
MOBILE:	HOME:	
GENDER: ☐ MALE ☐ FEMALE	PRONOUN: ☐ HE/HIM ☐ SHE/ HER ☐ THEY/ THEM	SSN:
MEDICAID#:	MASS H#:	SCO ID:

☐ Fallon Navi Care ☐ CCA ☐ United Healthcare ☐ Tufts / Point32 ☐ Senior Whole Health ☐ Other _____

DEMOGRAPHICS

MARITAL STATUS: ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ SINGLE

LIVING ARRANGEMENTS: ☐ INDEPENDENT ☐ SPOUSE ☐ CAREGIVER ☐ BHA ☐ OTHER: _____

PRIMARY LANGUAGE: _____ SECONDARY LANGUAGE(S): _____

ENGLISH FLUENCY: ☐ FLUENT ☐ LIMITED ☐ VERY LIMITED ☐ NONE ☐ UNKNOWN

LITERACY: ☐ FULL ☐ ILLITERATE ☐ REFUSE

HIGHEST LEVEL OF EDUCATION: _____

RACE: ☐ WHITE ☐ LATINO(A) OR HISPANIC ☐ ASIAN ☐ AFRICAN AMERICAN ☐ _____

PLACE OF BIRTH: _____

VETERAN ☐ YES ☐ NO

CITIZEN STATUS: ☐ U.S. CITIZEN --- or -- U.S. PERMANENT RESIDENT ☐ YES ☐ NO ☐ OTHER: _____

RELIGIOUS PREFERANCE: _____

COMMUNICATION DEFICITS: ☐ YES ☐ NO

BEHAVIORAL SYMPTOMS: ☐ YES ☐ NO EXPLAIN: _____

ALLERGIES & REACTIONS (FOOD/MEDICATION): _____

_____

DO YOU HAVE ANY OF THE FOLLOWING? ☐ FULL CODE ☐ DNR ☐ HEALTHCARE PROXY ☐ LEGAL GUARDIAN ☐ POWER OF ATTORNEY

PLEASE PROVIDE COPY OF THESE DOCUMENTS

DOES THE PARTICIPANT HAVE ANY HOBBIES/INTERESTS:_____

WHAT WAS THE PARTICIAPNTS OCCUPATION? _____

WHY DO YOU REQUIRE ADH SERVICES? _____

GOALS THE PARTICIPANT IS LOOKING TO ACHIEVE: _____

PRIMARY EMERGENCY CONTACT

NAME:		RELATIONSHIP:
ADDRESS:		
PHONE: ☐ HOME ☐ MOBILE		EMAIL:

OTHER EMERGENCY CONTACT

NAME:		RELATIONSHIP:
ADDRESS:		
PHONE: ☐ HOME ☐ MOBILE		EMAIL:

PARTICIPANT ENROLLMENT APPLICATION

It is required that an applicant has a physical examination by a physician within 12 months prior to admission to the program. Date of last exam: _____

PRIMARY CARE PHYSICIAN: _____MD /NP /PA
ADDRESS: _____
PHONE: _____ FAX: _____

CASE MANAGER: _____ PHONE: _____

COUNSELOR OR PHSYCHIATRIST: _____ PHONE: _____

HOSPITAL: _____

DIAGNOSES: _____

REASON FOR REFERRAL: _____
☐ Unstable / potentially unstable diagnosis

Client has one or more of the following diagnoses (check all that apply):

☐ Diabetes	☐ CHF	☐ COPD	☐ Recurrent UTI's	☐ Edema	☐ Dementia
☐ Obesity	☐ Stroke	☐ ALS	☐ Parkinson's	☐ TBI	☐ MS

☐ Other: _____

☐ Medication regimen affecting plan of care ☐ Mobility issues affect plan of care

Client has one or more of the following conditions (check all that apply):

☐ Poor balance	☐ Poor transfers	☐ Fall history	☐ Deconditioning
☐ Unsteady gait	☐ Poor hand / eye coordination		☐ Limited ROM
☐ Uses wheelchair	☐ Uses walker	☐ Uses cane	

☐ Current or potential skin problem
☐ Nutritional status affecting plan of care
☐ Other: _____

Do you receive services from other agencies? ☐ NO ☐ YES
Name of Agency: _____ Services: _____
Days: _____ # of Hours Per day: _____
PT/OT/SPEECH: _____ Specific Instructions: _____

Mark all that apply:			
☐ Mentally alert ☐ Forgetful ☐ Confused	☐ Able to get in and out of car ☐ Able to transfer chair to toilet ☐ Walks unassisted ☐ Walk using aids (canes, crutches, walker) ☐ Climbs stairs ☐ Showers shelf ☐ Shower support ☐ Dresses self ☐ Dress support	Bladder: ☐ Continent ☐ Incontinent ☐ Wears Briefs Bowel: ☐ Controlled ☐ Involuntary	☐ Feeds self ☐ Special Diet ☐ Self Care ☐ Wears Glasses ☐ Hearing Aids ☐ Dentures ☐ Top ☐ Bottom ☐ Both

Is the participant a smoker? ☐ NO ☐ YES *(if yes please read and sign the smoking policy)*

SPECIAL INSTRUCTIONS OR ANY OTHER INFORMATION WE SHOULD KNOW/ Use this space to give further details about the participant
_____
_____
_____
_____

All applicants will be scheduled for a center visit prior to admission.
This will be arranged by our Admissions Director.

MEDICATION POLICY

In order to meet your health needs, we need your assistance and cooperation. The following policies regarding medications are outlined for your information.

Please bring a list of **all** your medications when you come for your first day at Happy Health Center. Be sure to include all prescriptions and non-prescription drugs such as laxatives, allergy medications and vitamins. This enables the staff to develop a medication profile for you.

If you will be taking any medication during the hours you are at the Center, the following policies must be observed:

1. Medications must be prescribed by the participant's physician and will be administered by the Nurse at the prescribed times.

2. All medications accepted by the Center must be in the original pharmacy container. All must be in separate containers.

3. All container labels should include the following:
    a. Your Name
    b. Name of medication
    c. Dosage and Frequency
    d. Physician's Name
    e. Date the prescription expires
    f. Any appropriate cautions or interactions

4. You or your family/caregiver will send enough medication for at least 2 weeks – but no more than a 30 day supply - to be kept by the Registered Nurse in a locked cabinet.

5. You or your family/caregiver will refill the medicine bottle(s) when it is send home empty. The nurse will call if the medications are not received on the next scheduled day of attendance.

6. When participants present common complains, such as headache or indigestion, the nurse will administer non-prescription drugs according to standing orders prepared and signed by the participants attending physician.

7. Changes of additions in medications must be reported to the Nurse by your physician or they will not be administered.

8. If you no longer attend the Center, your medications should be picked up by you. The Center will keep your medications for one week after your discharge. The Center will then destroy the medications.

If you have any questions about medications, please call and talk to the Registered Nurse at the Center.

Participant Name: _____ Date of Birth: _____

Signature: _____ Date: _____

CONSENT TO SERVICE AGREEMENT

Participants Name: _____ D.O.B: _____

Participant's Potential Weekly Schedule: ☐ MON ☐ TUES ☐ WED ☐ THURS ☐ FRI

Happy Health Center, ADH provides customized program services for each participant. Services or programs may include: therapeutic services, socialization, nursing services, medication administration, nutritious meals, physical therapy services, transportation, personal care, hygiene, grooming, activities, and entertainment. In consideration of admission to the Happy Health Center, ADH program, I/We agree to abide by the following policies of Happy Health Center, ADH:
Our Adult Day Services are open Monday through Friday 8:00 am to 4:00 pm. Happy Health Center, ADH is closed on New Year's Day(Observed), Memorial Day, Juneteenth, Independence Day, Labor Day, Veteran's Day, Thanksgiving Day, Christmas Day.

1. Our Adult Day Center has no initial administration fee.
2. Current rates for services at Happy Health Center, ADH for private paying participants is $107 per day for basic care and our Complex rate is $136. Rates are based on attendance of 6 hours or more. Rates are subject to change.
3. Transportation is available through the Center. The fee is $29(one way) for ambulatory participants and $35(one way) for wheelchair transport. Rates are subject to change with 30 day notice.
4. Happy Health Center follows an ***attendance policy that requires a minimum of 2 days per week, 8 days per month***. Should the participant attend less than two days a week and is absent more than 3 months Happy Health Center, may terminate a participant's enrollment.
5. Happy Health Center will terminate a participants enrollment if participation is considered not in the best interest of the participant, or the best interest of the program, or its participants.
6. In case of an emergency, participants family and/or private physician will be contacted and will be required to make immediate arrangements for participants care outside Happy Health Center.
7. Participants must call and cancel if unable to attend the program on a scheduled day by 7:00 AM, in order for both hot lunch and transportation services to be cancelled.
8. Happy Health Center shall not be responsible for any money, valuables, or personal; effect brought into the facility by the participant or by relatives or friends.
9. All enrollment forms must be completed by the Participant, Guardian, or Power of Attorney.
10. Happy Health Center is available through contracted services that are arranged by the Center. Participants are to be dressed, waiting safely near the door, and ready for scheduled pick up. Participants who choose to utilize public or any other means of transportation herewith agree from to hold Happy Health Center inculpable and not to seek indemnity for any damages, costs and legal expenses involved in any suit brought by the participant as a result of the transportation of participant.
11. Medications can be monitored by the nurses at happy Health Center. All medications have to be in current pharmacy labeled bottle, stating the name of the physician, medication, date, and time in order to be administered as required. Nurses will reach out to the physician for further information.
12. If Happy Health Center should close on account of inclement weather, the center will be following the same protocol as Taunton Public Schools. If there are other circumstances, such as power outages, you will be notified as soon as possible of a closure.
13. A progressive grievance procedure is followed by Happy Health Center. Complaints are first referred to the Executive Director, and then to the Owner. If satisfaction does not result, then contact the state licensing division (617)222-7485. All complaints or concerns regarding confidential participant health information should be directed to the HIPPA privacy officer.
14. I agree to, and understand the following:
15. In the event of non-life threatening incident or illness, the staff will notify the designated responsible party or the physician of the participant and ask that all necessary arrangements be made to allow definite care. If an emergency situation arises resulting in a life-threatening condition, our staff will be obliged two procure the service of the most expedient emergency ambulance available and to transport the participant to the hospital designated on the Enrollment/ Intake Form.

_____ _____
Participant's Signature Date

_____ _____
Guardian/POA/Responsible Party Signature Date

ADMISSION POLICY

Participant Name: _____ Date of Birth: _____

Policy: To provide for & facilitate fair and informed admission to the Happy Health Center.

The participants of Happy Health Center will be adults with physical, emotional or mental impairments who require mild to moderate assistance and/or supervision.

PROCEDURE PURPOSE: To insure an orderly process and set forth the requirements for consistent and appropriate selection and admission of participants.

- Ambulation:
  - Must be able to ambulate independently or with assistance of wheelchair or walker.
  - Must be able to transfer with one person.
  - Must be able to bear own weight.
- Feeding:
  - Must eat independently or with minimal cueing.
- Toileting:
  - Must be able to toilet independently or with a one person assist
- Program Participation:
  - Participant will participate 50% of the time.
  - Participant will benefit from the social environment as evidenced by interaction with others.
- Supervisory Requirements:
  - Participant will benefit from a group setting with a staff: group ratio of 1:5.
- Wandering:
  - Participant should be redirectable in his/her wandering.
  - Participant should be willing to remain in secure area.

2 Week Trial - All participants are on a 2-week trial basis and if deemed to be inappropriate for adult day services participant will be discharged. *Please review the discharge policy.*

The participant or family caretaker will sign this admission/non-admission/discharge form honestly and to the best of their ability.

I HAVE READ AND HAVE ANSWERED QUESTIONS AND ACKNOWLEDGED KNOWN BEHAVIOR OF THE PARTICIPANT REQUESTING ADMISSION HONESTLY AND TO THE BEST OF MY ABILITY.

Signature _____ Date _____

DISCHARGE POLICY

Participant Name: _____ Date of Birth: _____

Policy: To provide for & facilitate fair and informed discharge from the Happy Health Center program.

PROCEDURE PURPOSE: To insure an orderly process and to set forth the requirements for consistent and appropriate selection and dismissal of guests.

Those who are not eligible for admission include those persons who require more assistance than the Center staff can provide, are beyond the scope of services, those who have a contagious disease, and those who are a danger to themselves or others.

Due to the congregate nature of the program, Happy Health Center ADH reserves the right to refuse services.

All Happy Health Center participants will be monitored on a weekly basis to determine whether or not they meet any of the criteria for discharge. THIS WOULD INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING:

- Ambulation:
  - Guests who cannot pivot for transfers, need lifting and those who cannot bear weight.
- Feeding:
  - Those who need assistance which may require continual queuing.
  - Those who display eating habits which are unacceptable in a group setting.
- Toileting:
  - Persons with frequent urinary/bowel incontinence requiring more than minimal assistance by staff.
  - Consistent body odor due to poor hygiene with unwillingness to improve.
- Program Participation:
  - If the participant sleeps excessively or isolates, not participating in program activities 50% of the time.
- Supervisory Requirements:
  - 1:1 staff needed to be with the participant more than one third of the time.
  - If medical condition or diagnosis requires 1:1 nursing supervision beyond our scope of care.
- Wandering:
  - If participant is non-redirectable in his/her wandering.
  - Participant repeatedly refuses to remain within secure area.
- Disruptive and Unacceptable Behavior:
  - Combative behavior, such as hitting, kicking, grabbing, spitting etc., are grounds for immediate discharge. A deteriorating physical/mental condition resulting in a participant being a danger to himself or others. Threatening others physically or verbally.
  - Inappropriate language such as swearing, cursing, insulting or berating others.
  - Sexual comments and gestures. Inappropriate sexual conduct.
  - Frequency and intensity or duration of participant's behavior continues after being explained the expectations and after staff interventions the situation remains uncontrollable and non redirectable. Disruptive behavior that affects the health, happiness and well-being of the other participants and /or the effective operation of the program.
- 2 Week Trial:
  - **All participants are on a 2-week *trial* basis and if deemed to be inappropriate for adult day services, the participant will be discharged.**

If one or several of the discharge criteria have been met by a participant, the Director/nurse will notify (in writing) the participant and his/her family of the need to change arrangements. Thirty (30) day notice will be provided; however the Happy Health Center reserves the right to immediately suspend, without proper notice.

Signature _____ Date _____

RELEASE FORM SIGNATURE SHEET

Participant Name: _____ Date of Birth: _____

☐ AGREE ☐ DISAGREE

MEDIA RELEASE FORM

I, _____PARTICIPANT LISTED ABOVE_____ hereby grant Happy Health Center permission to use my likeness in photographs and/or video in any and all of its publications, including Web space, and in any and all other media, including social media platforms, whether now known or hereafter existing, controlled by Happy Health Center, in perpetuity, and for other use by the Center. I will make no monetary or other claim against Happy Health Center for the use of the photographs and/or video. I understand this release can be withdrawn at any time.

☐ AGREE ☐ DISAGREE

OFF PREMISES RELEASE

I hereby grant Happy Health Center, ADH permission to escort _____PARTICIPANT LISTED ABOVE_____ off premises for an outing, as in: going to lunch, a walk, the park etc.

LOST, STOLEN OR MISPLACED ITEMS

Happy Health Center, ADH is *NOT* responsible for lost, stolen or misplaced personal items. However, if notified and/or found within a reasonable amount of time, the Center will return those items to the owner.
WE ADVISE YOU TO LEAVE ANY VALUABLES AT HOME. PLEASE DO NOT BRING THEM WITH YOU.
I, _____PARTICIPANT LISTED ABOVE_____, agree to the terms of this notice.

NOTICE OF PRIVACY PRACTICES & RIGHTS AND RESPONSIBILITIES
RECEIVED AND SIGN OFF

I, _____PARTICIPANT LISTED ABOVE_____, am signing this document as proof of receiving a copy of the Notice of Privacy Practices, as well as the Members' Rights and Responsibilities from Happy Health Center Taunton.
**(EVERY PARTICIPANT RECEIVES THESE TWO DOCUMENTS)*

_____ _____
Signature of Participant or Authorized Representative/ Relation Date

NO SMOKING POLICY

Happy Health Center is a smoke-free establishment.

The ultimate objective of this policy is to eventually have a smoke free facility, while at the same time respecting the rights of current participants who are smokers.

Out of concern for the effects that secondhand smoke has on those with respiratory, or other health related conditions, Happy Health Center has approved the following policy.

"Smoking" means inhaling, exhaling, burning, or carrying any lighted cigar, cigarette, pipe, weed, plant or related substance or product, including vaping.

A. REGULATIONS OF SMOKING INDOORS:

- Smoking shall be prohibited in all enclosed areas of Happy Health Center.

This includes, but is not limited to, the ballroom, all common areas, the media/movie room, craft room, hallways, restrooms, motor vehicles owned or leased by Happy Health Center, and any other enclosed areas.

- Smoking is prohibited in all Happy Health Center vehicles at all times.

B. REGULATION OF SMOKING OUTDOORS:

- Happy Health Center prohibits smoking in all outdoor areas, except the designated smoking area provided. This is an area that is physically accessible to all participants, and located a reasonable distance from the main entrance to ensure that tobacco smoke does not enter the enclosed areas of Happy Health Center.
- Participants and guests are allowed to use the outdoor designated smoking area at these specifically designated times, and are escorted by a Program Aide to ensure participant safety:
  - 9:15 am (after breakfast)
  - 12:30 PM (after lunch)

Participants and employees may be allowed to utilize the designated smoking area. If participants need supervision in order to utilize the designated smoking area, employees shall be given the choice whether they wish to supervise a person served and thereby be exposed to secondhand smoke. Employees shall be given the right to refuse to accompany a participant to the designated smoking area.

NO SMOKING POLICY AGREEMENT

I understand that Happy Health Center has a No Smoking Policy that prohibits smoking in any of the common areas, within all enclosed areas of the Center. I also understand that there is a designated smoking area that participants and guests who smoke may use.

I have received and read a copy of the Happy Health Center, No Smoking Policy, and agree to abide by its provisions.

_____

Participant Name Printed

_____ _____

Participant Signature Date

REV JAN 2024

CIVIL RIGHTS COMPLIANCE – PARTICIPANT INFORMATION

In accordance with applicable Federal and State civil rights law and regulatory requirements, as a Participant of Happy Health Center, you have the right:

To be provided services at this facility and be referred for services at other facilities without regard to your age, race, color, religion, sex, sexual orientation, handicaps, disabilities or national origin.

If you feel that you have been discriminated against on the basis of any of the above, complaints of discrimination may be filed with any of the following agencies:

Executive Office of Elder Affairs
One Ashburton Place, 5th floor
Boston, MA 02108
(617) 727-7750

Executive Office or Elder Affairs,
Elder Abuse Hotline
1-800-922-2275

Attorney General's Consumer Advocacy
& Response Division
Consumer Hotline (617) 727-8400

Department of Children and Families
1-800-792-5200

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free Call Center: 1-877-696-6775

_____
Participant Name

_____ _____
Participant Signature Date

_____ _____
Guardian/ POA/ Responsible Party Date