MARSHFIELD AREA RESPITE CARE CENTER, INC
MARCC
P.O. Box 485
Marshfield, Wisconsin 54449-0485
715-384-8478

ENROLLMENT AGREEMENT

PARTICIPANT'S NAME_____

CAREGIVER'S NAME_____
Relationship_____

ENROLLMENT DATE_____

PROGRAM:

The services of MARCC are offered to enhance the quality of life for the participant and caregiver by offering safe opportunities for socialization and activities and may maintain or improve the level of functioning of the participant and give time free of care responsibilities for the caregiver.

BASIC SERVICES

1. Observation and supervision in a safe, comfortable environment.
2. Daily observation of participant's general health and behavior.
3. Supervision of noon meal and snacks/beverages.
4. Assistance with personal care needs.
5. Social/recreational activities planned to meet participant's level of ability and interest.

EMERGENCY CARE

MARCC staff will notify the caregiver of illness and call 911 for emergency care. It is noted that when emergency personnel are present, they are required to perform emergency life support measures.

ELIGIBILITY

MARCC will serve an older adult with memory loss in need of basic care and socialization. The participant must be continent or able to wear protective undergarments. It may be necessary to provide a change of clothing. This is not intended to deny participation in the event of an occasional incident of incontinence. The participant must also be free from any infectious disease. MARCC does not discriminate on basis of disability, race, religion, or ability to pay.

CENTER POLICIES

1. MARCC provides a social model daycare/respite program. It is not licensed for and cannot provide medical/nursing services including the administration of medications. They will, however, remind a participant of the need to take a medication if it is absolutely necessary during hours of participation.
2. Days and hours of operation are Monday through Friday, 10:00 a.m. to 4:00 p.m. Participants may attend half or full days.
3. MARCC will be closed on legal holidays.
4. MARCC Inc., staff, volunteers or other participants will not be held responsible for any money, valuables or personal effects brought to the Center.
5. Participants will be monitored as closely as possible, but the Center staff will not be responsible for participant's wandering or potential elopement away from the Center.
6. Medications, food or beverages may not be brought into the Center without the knowledge of the Center staff.

FAMILY/CAREGIVERS RESPONSIBLITIES

1. To ensure that participants arrive and depart on time.
2. Call the Director before scheduled arrival time to report an illness or other reason the participant will not be coming on a given day.
3. Furnish changes of clothing or protective garments as may be needed for participant.
4. Disclose information that would be helpful in meeting the needs of the participant during the program planning process or in the event of an unusual incident such as a fall, new medication, etc.
5. Participate in care planning and evaluation of the participant's activities at the Center to maximize the benefit to the participant and caregiver.

FEES

The fee at MARCC is **$36.00** for a full six-hour day or $**18.00** for a half day or less. This fee includes a meal, if served during the hours of participation, and two snacks a day. No participant will be denied participation if unable to pay the stated fee. Referral will be made to the Aging & Disablity Resource Center for assessment of eligibility for financial assistance if requested. If no funds are available through that agency, a sliding scale will be used to establish a rate acceptable to the family. Center staff caregivers will not be involved in the financial arrangements/decisions. Thirty days notice will be given if it is necessary to change the fee or the days or hours of operation.

PARTICIPANTS RIGHTS

As participants in the Marshfield Area Respite Care program, you and your family member are entitled to the following rights:

1. The right to be treated with respect and dignity.

2. The right to be free from physical or verbal abuse.

3. The right to participate in the development of one's service plan, with support from staff and caregiver.

4. The right to refuse to participate in any particular activity.

5. The right to privacy and confidentiality.

6. The right to be fully informed of all the services provide and the charge for those services.

7. The right to be informed of the reason for discharge and the procedures for appealing that decision.

8. The right to initiate a complaint and be informed of the complaint procedure.

CONSENTS

It is necessary to have consent for a number of things. Please initial all spaces where you give consent or cross off those to which you do not consent. The signature of the caregiver at the end will validate the initials or deletions. It is noted that all consents are for the participant named at the beginning of this document. In addition to those consents included in this document, you will be asked to sign a consent for emergency treatment, which can be given to the physician and hospital if it should be necessary.

PERMISSION TO OBTAIN EMERGENCY MEDICAL CARE

I authorize the Marshfield Area Respite Care Center staff to seek emergency medical care while he/she is in attendance at the Center program. I understand it may be necessary to call 911 for emergency help and my family member will be transported to the Marshfield Medical Center. I further understand that if 911 is called the emergency personnel are required to initiate life support measures.

Dr. _____is _____'s physician and his/her Clinic number is _ _ _ _ _ _ _ (Availability of this number, which is the medical record number, will facilitate a response to the emergency). ____**Initial**

Special instructions:

_____has an Advance Directive (Durable Power of Attorney for Health Care or Living Will) and has stated he/she does not want Cardio-pulmonary Resuscitation done. I do understand that if emergency personnel have to be called, they are required to initiate resuscitation, but the staff at the Hospital will be informed of the existence of an Advance Directive--Power of Attorney for Health Care or Living Will. A copy of this document is in the Medical Record yes___, no___. _____ **Initial.**

PHOTOGRAPH/ACTIVITY CONSENT/RELEASE

I hereby consent to the following as part of the MARCC program:

___I understand a photo will be taken for identification purposes as required for State certification.

___I understand that individuals from the community, in addition to the regular volunteers, may come to the Center to participate in activities or services such as music, crafts, drama, etc.

In addition to the photo taken for identification purposes,

Yes__ No__ Photos may be taken for use in the Center or for family use.

Yes__ No__ **Photos may be taken for MARCC website, Facebook, and public use.**
_____ Initial

CONSENT FOR FIELD TRIP

In order to provide a varied and stimulating program at MARCC, occasional field trips or outings may be taken. Transportation will be provided by private car, on foot, by the Department of Aging bus or by taxi van. During each outing staff and volunteers will exercise reasonable and sufficient care to insure participant's safety.

The Center will not be liable for any unforeseen accidents or difficulties which might arise during outings.

You will be notified if there is a charge for admission or transportation. We plan these outings as stimulating and enjoyable activities for each participant. _____**Initial**

MEDICATION WAIVER

I hereby authorize the staff of the Marshfield Area Respite Care Center to hand medication to _____, a participant in the Center. I understand that the staff of the Center cannot administer medications.

I will pre-measure the medication(s) and check to insure that the drug(s) and dosage are consistent with the physician's instructions and is properly labeled. Only required doses for the day will be furnished and only when the administration schedule cannot be accommodated outside the hours of participation.

I hereby release the Marshfield Area Respite Care Center staff from any and all liability pertaining to the use of (list names of all medications).

_____

_____ _____ **Initial**

I have read this complete document and indicated my approval of appropriate items by an initial or have crossed them off to indicate my wishes.

Signed _____Initial_____ Relationship _____

Witness_____ Title_____

Date_____

The original copy of this document will be placed in the participant's file and a copy will be made and returned to you.