First United Methodist Church of Dothan
Respite Ministry Program

1380 West Main Street
Dothan, Alabama 36301
334-793-3555

POLICIES AND PROCEDURES MANUAL

Governing Body

Respite Care is a program of the First United Methodist Church of Dothan.

Purpose

FUMC Respite Ministry is designed to meet the social and emotional needs of older adults and their caregivers. It provides activities and socialization opportunities outside the home in a safe and caring setting for older adults with mild to moderate memory loss. It provides their caregivers with emotional support through a caregiver support group, information regarding available resources, and personal time away during the day in which to rest and address their own needs. No medical care is provided.

Services Offered

For the Older Adult Participant:

This ministry provides a safe, loving environment for the well-being of each participant. A variety of activities includes, but is not limited to, social, creative, intellectual, spiritual and recreational programming. All activities are designed to provide mental stimulation and social participation. Examples of activities include group singing, gardening, crafts, community services, reminiscing, exercise, adapted floor games, intergenerational programs, art therapy, pet therapy, and socialization activities.

For the Caregiver:

This ministry provides respite (an interval of rest or relief) for the caregiver. It supports the efforts of the family to keep the loved one in the home environment, which will contribute to the quality of life of the participant as well as the family. This ministry offers a monthly support group with an experienced staff member. It also provides information regarding available community resources, nursing home options, Alzheimer information, etc.

Hours, Days of Operation, Location

FUMC Respite Program operates Monday through Thursday from 10:00 a.m. to 2:00 p.m. in Rooms 152 and 155. The program will be closed on all legal holidays, i.e., New Year's Day, Martin Luther King Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day, and other holidays that fall on program days. Advanced notification of closing will be communicated to participants and caregivers. If the Houston county schools are closed for inclement weather, we will also be closed.

Admission Criteria

Participation in the program will be based on the applicant's ability to participate in the program and the initial interview with the director. Taken into consideration when evaluating whether an applicant is capable of participating in the program are the following:

- Medical stability – a participant may be frail and have physical problems, but must be medically stable.
- Ability to ambulate independently with or without assistive devices without potential danger to self or others
- Ability to perform daily living activities independently.
- Ability to interact and socialize with others.
- Ability to exhibit acceptable behavior in a group

The following may be examples for excluding an applicant from FUMC Respite Care Ministry:

- Unmanaged incontinence
- Disruptive or combative behavior
- Psychosis
- Communicable disease or unstable medical problem
- Need for one-on-one continual supervision

Admission Procedure

1. A telephone interview will be conducted by the director, followed by (if potential participant meets criteria) an invitation to visit the program for a day with the participant and caregiver attending. Following assessment an application will be given to the caregiver to be returned to the director.

2. The admission application is processed and the applicant and family are informed of the decision.

3. The participant/family completes the enrollment form.

Discharge/Termination Criteria

Examples of reasons for discharging a participant from the program are generally the same as those listed under Admission Criteria (examples for excluding an applicant section.)

If the caregiver is no longer satisfied with our program or a participant is no longer able to take part in the program due to physical or mental deterioration, the director reserves the right to discontinue the participant from the program. The caregiver will be contacted by phone, e-mail or in person about the need for discharge of the participant. At this time, the director will provide the family with suggestions of program options in the Houston County area that may better serve their needs. Successful placement is not the responsibility of the staff of FUMC Respite Ministry.

Discharge/Termination Procedure

Consideration of discharge from the program will be discussed with the family member(s) before final decision of termination is made in order to give as much advance notice as is reasonably possible. Upon the final decision, that discharge will occur and any daily fees paid in advance will be refunded.

Payments/Rates/Attendance

There is a daily fee of $30 per day for participation in the program, which is paid monthly. Statements are issued at the beginning of each month for the number of days the participant will attend the program. Payment is expected on the 10th of each month in order to ensure uninterrupted participation in the program; any account that remains unpaid after the 10th of the month will incur a $10.00 late fee.

Participants are expected to attend the program as scheduled. Caregivers are asked to notify the director by 9:00 a.m. if the participant will not be in attendance that day. Non-attendance affects both staffing and meal ordering. Regular $30 a day payment will be charged on days participant is scheduled to attend, but cancels.

Staffing

A director and assistant director will staff the program. The director and assistant director will be trained in CPR and first aid. In the director's absence the assistant director will be in charge of the operation and activities of FUMC Respite Ministry. Trained volunteers provide additional staffing and are assigned participants with whom they will socialize during the day. The ratio of volunteers to participants may vary from 2-4 participants to one volunteer, depending upon individuals. Each program day will be considered "full" when it numbers 20.

Nutrition

A mid-morning snack upon arrival, a nutritious lunch and an early afternoon snack (on an as-needed basis, prior to departure) will be served daily. Beverages such as decaffeinated coffee and tea, water and juices will be available to participants during the day.

Communication

It is of great importance that lines of communication between caregivers and the program director remain open. If the family of the participant has concerns, observations and/or suggestions they would like to discuss, they are always encouraged to do so. This can be best accomplished by scheduling an appointment with the director.

Medication/Health/Injury

The director will keep a confidential file for each participant, which will include the following:

- Admissions application
- Enrollment documents
- Consent for emergency treatment
- Bill of Rights
- Photo release form
- Living Will (if applicable)

Participants needing to take medication(s) during program hours must be able to take it/them independently. Participants must keep the medication with them during the day, as we are unable to store medications. Program staff will remind a participant to take his/her medication; however, they are unable to administer any medications. Family members must take full responsibility for medication administration.

No one on staff is a medical professional. If a participant shows signs of illness or infectious disease, the director will contact the participant's caregiver, advising her/him to pick up the participant.

Sickness and accidents resulting in physical injury or suspected physical injury will be reported to the director, who will arrange for appropriate medical attention. The caregiver of the participant will be immediately notified or emergency actions taken. If determined to be necessary, transportation to the hospital will be obtained by calling 911. An accident report will be filed with the signature of the caregiver.

Paid Attendants

Participants may choose to have their personal paid attendant with them during the program hours. Paid assistants will provide necessary aid to their own client, but will be expected to assist their client in participating in the activities as scheduled. They will also be responsible for payment of their own meals.

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Financial Contract

As a family member/caregiver participating in the **First United Methodist Church Respite Care Ministry**, I agree to the following:

The monthly amount I agree to pay is based on the number of days per week _____ is enrolled in the **Respite Ministry** and reserves a space in the program for those days.

The amount due for the **Respite Care Ministry** remains the same even if the participant is unable to come to the program for any reason. A "Make Up Day" may be requested if the program has a slot available. No "Make Up Days" will be allowed for **On-Site Respite Care Ministry** holidays or other closings. "Make Up Days" must be used within 30 days of absence.

In the event of hospitalization, prolonged illness, or other extended absences, and the participant is unable to come to the **Respite Care Ministry** , the caregiver may dissolve the contract anytime. However, if the caregiver wishes for the participant to return to the program, it is necessary that the participant slot be held with continual payment. If the caregiver wishes to dissolve the contract, but is unable to commit to a specific date, the participant can be placed on the waiting list, and be offered a slot when it comes available.

We desire to participate in the **Respite Care Ministry** _____day(s) a week.
We agree on the amount of $_____ a day.

The pro-rated amount for this month of_____ is $_____.
I understand that full payment is due starting the first full month.
I understand that all fees are considered late after the 10th of the month. If the **Respite Care Ministry** has not received payment in a reasonable amount of time, the Director may discharge the participant from the program.

The Director has gone over the above conditions with me. I understand and agree to them.

_____ _____
Signature Date

STATEMENT OF MEDICAL CONDITION

Dear Physician:

This patient has applied to attend ***The Respite Care Program of First United Methodist Church, Dothan.*** Please certify that he/she is free of communicable diseases and has had the necessary and appropriate immunizations.

Name_____Birthdate_____

Address_____City/StateZip_____

Diagnosis_____

Date of last: Flu shot_____ Pneumonia vaccine_____

Tetanus Toxoid_____

TB test_____ Results were positive _____negative_____

Allergies: _____

Please circle the recommended diet for this patient:

Regular Low Salt Low Cholesterol Diabetic/low calorie

Other_____

Special considerations/precautions/comments:_____

_____

I certify that the above-named patient is free of communicable diseases and recommend his/her participation in the FUMC Dothan Respite Care Program.

Signature_____Date_____

Address_____

Current Medications List

Respite Care MINISTRY

Name: _____ **Emergency Contact Name/Phone:** _____

Date Last Updated: _____ _____ _____ _____

Prescription Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes

Pharmacy/
Allergies

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Consent for Emergency Medical Care

As a participant in the Respite Care Ministry Program of First United Methodist Church of Dothan, I hereby give permission to staff (paid and volunteers) to provide direct minor emergency care for minor emergencies or to access 911 emergency medical services as deemed necessary. I hereby give my full and unconditional approval for said staff to secure emergency medical care.

Any resultant bill will be the responsibility of the participant and /or caregiver/guardian. Said individual(s) will be responsible for filing any and all medical insurance claims.

In the event a medical situation is not an emergency, staff may request that a doctor see the participant. It is understood that the participant cannot return to the program without a report concerning the incident.

I will not hold any of the staff (paid or volunteer) of FUMC Respite Care Program responsible for any injury, which occurs to the named participant during the course of the program. I acknowledge that FUMC Dothan cannot and does not assume responsibility for undesirable incidents or injuries should the participant leave the program site without permission.

Every reasonable effort will be made to ensure the safety of the participant.

Name: _____ Date: _____

Guardian (relationship)_____ Date: _____

Signature: _____

Participant's Physician Name and Phone #:

_____

Hospital of Choice: _____

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Photo and Field Trip Release

Name: _____ Date: _____

The above mentioned named participant gives permission and release for **Photographs** to be made of him/ her while engaged in program activities. These photos may be used for publicity/ promotion of **FUMC Dothan Respite Care Ministry** and also for identification purposes.

Participant_____ Guardian_____

The above named participant gives permission and release to participate in **Field Trips and Outings** by FUMC Dothan Respite Care Ministry. Every effort will be made to insure the safety of the participant.

Participant _____ Guardian _____

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Application Form

Full Name: _____ Date: _____ Fee Paid: _____

Address: _____

_____

Male__ Female__ Birthday_____ Marital Status M__ S__D__Widow/er__

Presently lives with_____

How did you hear about our program? _____

EMERGENCY INFORMATION:

Doctor's Name, Address, Phone#:_____

_____

Hospital Preference: _____

ALLERGIC TO: _____

List All Physical Problems, including mental health and communicable diseases:

_____

_____

_____

List Any Dietary or Physical Restrictions:

_____

_____

List Medications/Dosage: _____

_____

_____

CAREGIVER CONTACT INFORMATION:

Caregiver's Name: _____ Relationship_____

Address if different from participant: _____

Home Phone#_____ Cell Phone #_____ Work Phone #: _____

E-mail Address: _____

Alternate Contact Person: _____ Relationship_____

Address_____

Home Phone #_____ Work Phone #_____Cell Phone#_____

Use back for any additional information we may need to know to aid in the participant's care

_____ I have received and read a copy of the policies and procedures of

FUMC Respite Care Ministry.

Social Interaction (Enjoy large social functions? Small groups? Alone?):

_____

Comments: _____

_____

_____

_____

Participant Will Be Picked Up By:

_____