ALZHEIMER
PARKINSON
ASSOCIATION
OF INDIAN RIVER COUNTY

Social Respite Program Policy & Procedure

To address the eligibility and safety elements of the Social Respite program, the following policies and procedures will be observed.

Eligibility

The Social Respite program is designed for adult individuals who, due to cognitive impairment, have diminished capacity for judgement and decision making. The purpose of the program is two-fold: to offer respite for the caregiver of someone with dementia; and, to provide stimulating engagement programs in a social setting designed for those with dementia.

This program is designed to fill the niche for those families whose loved one is in the earlier stages of dementia. It is offered in a **non-medical** setting and serves solely as a social support program. Ineligibility would be for the following reasons:

- Not a resident of Indian River County
- Not suffering from cognitive impairment
- Living independently
- Still driving
- Needs physical assistance
- Unable to self-toilet; unable to feed self
- Requires medication administration during program hours
- Behavior unsuitable for a social setting
- Risk of elopement*
  *Our office is NOT LOCKED and therefore we cannot force a participant to stay if they want to leave. Our organization is NOT liable if a participant leaves the building of their own free will.

The determination of eligibility will lie with the Director of Programs and/or the Executive Director. We recognize that progressive decline may eventually affect suitability for this program. We will continually evaluate and confer with the family to assure ongoing safety standards are met. As space allows, some participants may attend with a professional caregiver.

Capacity

Program growth and limited space require that we begin to institute a capacity policy. We will attempt to ease into this to allow our present participants the access to the program that they have established in their routine. We will establish a restriction on which days of the week new participants may join the program – this will be based on a review of attendance history.

Additionally, participants who are coming for just one program results in a safety issue for those who are attending for the day. Unfortunately we may have to restrict such attendance.

Please sign here to acknowledge our policies and procedures above:

Sign: _____ **Date:** _____

Social Respite Group – Information Sheet

Name of Participant: _____

Participant Street Address: _____ Unit#: _____

City: _____ Zip: _____ Veteran: □ Yes □ No Age _____

Responsible Party:	
Relationship:	
Home Phone Number:	
Cell Phone:	
Additional Contact Name: (In case responsible party is not available)	
Additional Contact Phone:	
Email Address:	

Presenting condition requiring respite: _____

Describe any physical impairments: _____

Is the Participant Self Sufficient Toileting: ☐ Yes ☐ No

Does the participant still drive a vehicle? ☐ Yes ☐ No

Are there any food allergies or restrictions we should be aware of (diabetic)?

Please be aware that we do have families who often bring in homemade cookies and other goodies to share. Please let us know if you do not want us to offer them to your loved one.

I understand that this is a social respite group designed for individuals who, due to cognitive impairment, have diminished capacity for judgment and decision-making. I further understand that this program is offered in a non-medical setting, which does not have locked doors to bar elopement. I appreciate that some aspects of the program may be delivered with the aid of volunteers.

Additionally, I recognize that dementia may cause behaviors that are unsafe in this setting or problematic to the group dynamics. Such a determination by the program leaders may render some participants ineligible for this program. With this understanding, I release the Alzheimer & Parkinson Association of IRC of liability while my loved one is engaged in this social program.

_____ _____

Participant or Caregiver Signature Date

Which location would you like to schedule? ☐ **IG Center (Tuesday)** ☐ **Sebastian (Thursday)** ☐ **Vero Beach**
☐ **Indian River Shores (Wednesday and Friday)** ☐ **Gifford (Monday and Thursday afternoon)**

Getting to Know You!

Participants Name: _____

Marital Status: ☐ M ☐W ☐S ☐D Spouses Name: _____

Birthplace	
Date of Birth / Age	
Mothers Name	
Fathers Name	

How many siblings do you have: _____ Birth Order_____

If you are not a Florida native, what year did you move here?_____

What brought you to Florida? _____

Interesting facts about your Parents:

_____

_____

Interesting childhood facts:

_____

_____

Do you like pets? YES or NO Do you have any pet allergies? Yes or No _____

Level of Education	
Area of Study	
Previous Occupation	

Military Experience: ☐Yes ☐No If Yes, which branch of service? _____

War Time Service or Other Military Information:

_____

_____

List other special facts about yourself:

_____

_____

Are there any special hobbies or interests?

_____

_____

Alzheimer & Parkinson Association of IRC (APAIRC)

PHOTO RELEASE FORM

I hereby grant the APAIRC permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of the APAIRC and will not be returned.

I hereby irrevocably authorize the APAIRC to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge the APAIRC from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHIOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

Participants Name: _____
(Print Name)

Signer Name/Relationship:_____/_____
(Print Name)

Signature_____ Date _____

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Acknowledgement of COVID-19 Risk

In consideration for being allowed to participate in the programs of the Alzheimer & Parkinson Association ("the Association"), I release from all liability the Association and its officers and employees related to exposure to the COVID-19 virus.

I acknowledge and fully assume the risk of exposure to Covid-19 which may arise from being on the premises and participating in programs. I understand that regardless of any precautions taken, an inherent risk of exposure to COVID-19 will exist. Notwithstanding these risks, I willingly choose to participate.

In signing this agreement, I acknowledge that I am legally allowed to sign on the behalf of the participant; and I execute this agreement fully intending to be bound by same.

Signature of Participant or Representative_____

Name of Participant_____

Relation to Participant_____

Date_____

Respite Program Assessment

Participant Name:_____

Assessment Date:_____ Date of Birth:_____

Please answer all of the questions below:

1. Does the participant have any allergies? ____ YES ____NO
   (If Yes please Provide a list in the lines below)

   _____

   _____

   _____

2. What is the participants current memory diagnosis?_____

***Upon arrival at our location, the participant and anyone accompanying them will be subject to a temperature screening and questionnaire prior to entering our program. If anyone reads a temperature of 99.8 or higher, they will undergo an additional temperature reading. After additional temperature reading, if the temperature is still 99.8 or higher, the participant will not be permitted into the program.

3. Has the participant shown a temperature screening of 99.8 or higher in the past 7 days?
   YES_____ NO____

***Please fill out the COVID- 19 Screening Questionnaire attached to this assessment.

4. Does the participant have a history of seizures? YES____NO___
5. Is the participant alert and oriented? YES____ NO____
6. Is the participant understandable and clear in their speech? YES___ NO___
7. Does the participant have any vision challenges? YES___ NO___ (if YES please explain:)

   _____

8. Does the participant have any hearing challenges? YES___ NO___ (if YES please explain:)

   _____

9. Does the participant have any respiratory issues? YES___ NO___ (if YES please explain:)

   _____

10. Does the participant have any incontinence issues? YES___ NO___ (if YES please explain:)

11. Does the participant exhibit any of the following behaviors: (please check all that apply)

___ Anger/Aggression ___ Agitation ___ Uncooperative ___ Anxious ___ Wandering

12. Is the participant able to ambulate without assistance? YES___ NO___ (if NO please explain:)

13. Is the participant able to transfer without assistance? YES___ NO___ (if NO please explain:)

14. Can the participant toilet themselves without assistance? YES___ NO___ (if NO please explain:)

15. Is the participant able to eat and drink without any assistance? YES___ NO___ (if NO please explain:)

16. Does the participant need to be administered medication during the program? YES___ NO___ (if YES please explain:)

17. Which can the participant engage in: (check all that apply)

___ One on One activities ___ Individual Activities ___ Small Group Activities ___ Large Group Activities

18. Would the participant be accompanied by a private caregiver while attending our program? ___YES ___NO

19. Are there any other conditions/circumstances that would affect the participants engagement in this program?

Please sign below certifying the primary caregiver of the participant has filled out this form and that the responses provided above are true and accurate to the best of my knowledge.

X_____ Date: _____

COVID-19 Screening Questionnaire

Participant Name: _____

Date:_____

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (Please take your temperature before you answer this question.)

Yes ☐ No ☐ High Temperature or Fever (99.8° F or greater as measured by a thermometer)

Yes ☐ No ☐ Cough

Yes ☐ No ☐ Shortness of breath or difficulty breathing

Yes ☐ No ☐ Sore throat

Yes ☐ No ☐ New loss of taste or smell

Yes ☐ No ☐ Chills

Yes ☐ No ☐ Head or muscle aches

Yes ☐ No ☐ Nausea, diarrhea, vomiting

2. In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact? Yes ☐ No ☐

3. In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? Yes ☐ No ☐

4. Have you been tested for COVID-19 and are waiting to receive test results? Yes ☐ No ☐

5. Have you have tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms? Yes ☐ No ☐

6. In the past 14 days, have you been on a commercial flight or traveled outside of the United States? Yes ☐ No ☐

7. In the past 14 days, have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? Yes ☐ No ☐

8. Is there any reason why you feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? Yes ☐ No ☐ (If "yes", please provide a brief explanation.)Explanation: _____.

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature:_____

Date:_____