Winter Growth

Adult Day Program

Benefits of Attending
Winter Growth's Adult Day Program

Physical Activity: Participants are encouraged to engage in daily exercise programs to maintain their strength and balance. Studies have shown that participation in fall prevention exercises can improve ambulation and decrease the risk of falls. Physical activity has also been proven to benefit the mind and age-related illnesses such as cardiovascular disease.

Social Interaction: Research shows that socialization and physical activity are important for all age groups. Winter Growth believes seniors and disabled adults have the ability to enjoy meaningful relationships and experiences, so each day we create opportunities for everyone to be an active member of the community.

The Opportunity to Continue to Live a Meaningful Life: At Winter Growth, we know the difference that days filled with engaging activities, laughter and friends make. Our person-centered programming is tailored to each individual's preferences, needs, and values.

Promotion of a Positive Self Image: We believe each person has the potential for growth and development. With support for functional limitations, each participant is encouraged to try new activities as well as to build on previous interests and accomplishments. Recognition and respect for even small successes helps to maintain dignity and build self esteem.

Medical Supervision: A registered nurse monitors the health and nutritional needs of participants and oversees the administration of medications needed during the day. The nurse also keeps in touch with both family members and physicians to support the health and well-being of all participants.

Respite: Family caregivers can take some time to run errands, go shopping, see their own doctors, get a haircut, exercise, have lunch with friends, take a class, or just rest and recharge.

Frequently Asked Questions

My family member just needs to be with other people. Is your day program appropriate? Our programs are tailored to meet the needs of a variety of participants. We have activities for individuals who need social interaction and separate activities for those with significant cognitive issues.

What are my fees paying for? In addition to a therapeutic activity program that includes two snacks and healthy lunch, fees provide for nursing oversight, disease and medication management, transportation, outings, and hands-on support for those needing assistance with eating, walking, or incontinence issues. Participants also have access to on-site physical, occupational, and speech therapy.

I need to leave early for work. How can you help? Our program offers hourly respite before and after our program for those families that need a longer day. A nominal fee is charged in the afternoon for additional hours.

What is overnight respite and how can it help me? With just a two day minimum, your family member can be in a safe environment overnight with all the services provided to our assisted living residents. Whether you have to be away for work, are attending a family gathering, or would just benefit from a few days alone, our overnight respite can provide the support you need.

My family member has memory issues. How safe is your facility? Our community offers a secure environment that reduces elopement risks and is conducive to healthy wandering both inside our building and outside in our enclosed garden area. While residents are free to walk and explore, staff is always watching to ensure that residents are safe.

Winter Growth has two locations…

In Montgomery County, our center is located on the campus of Montgomery General Hospital, at 18110 Prince Philip Drive, Olney, MD 20832.

In Howard County, our centers are located next to the Bain Center at 5460/5466 Ruth Keeton Way, Columbia, MD 21044.

For more information phone (301) 774-7501 in Montgomery County or (410) 964-9616 in Howard County and ask to speak to the Social Worker.

Admission/Discharge
For Adult Medical Day Care

Admission to Winter Growth's Medical Day Program, is based on if an individual:

1. Deemed an appropriate recipient of medical day care by a licensed physician.

2. Deemed appropriate by the Center Director based on a social work and nursing evaluation including being free of tuberculosis.

    a. Have own licensed private physician who is willing to work with and advise Winter Growth nursing staff on the care of the client, and respond with instructions in an emergency. The physician must have a licensed back-up physician designated at all times when he/she is not available. The back-up physician must be willing to respond to Winter Growth, providing instructions and advice on behalf of the individual client.
    b. Have the needed support during hours not cared for by the center.
    c. Demonstrate an ability to function within the program without causing undue disruption or danger to self or others.
    d. Not require full time one-to-one staff attention for their own protection and/or the protection of others.
    e. Be functioning at such a level that a less expensive type of program, such as a Senior Center Plus Program, a Senior Center, or county nutrition site, is unable to meet their needs.

3. The agency reserves the sole right to make all admission determinations. Admission is based on an evaluation of the program's ability to meet each individual's needs within a group setting that respects the rights of those served by Winter Growth.

Discharge from Winter Growth's Medical Day Program includes, but is not limited to:

1. Change in participant's health that cannot be met by the center's staff;
2. Behavior by participant that constitutes a substantial threat to the participant, other participants or staff;
3. Non-payment of fees includes by an agency if non-payment is due to individual's representative not completing required agency paperwork;
4. Problematic relationship between Winter Growth staff and the participant's family or other individuals involved in the participant's care that cannot be resolved.

Winter Growth does not discriminate on the basis of age, race, religion, ethnic origin, disability, or sexual orientation in eligibility for or the provision of any of its services.

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Now that I have read the brochure, where do I go from here?

This checklist is designed to help you understand the various steps involved in enrolling a family member in Winter Growth's day program.

_____ **Personal Tour –** Please contact social services to schedule a tour of our center. We will be happy to sit down with you to discuss the needs of your family member. An appointment is always appreciated, however you are welcome to stop by our center Monday through Friday. Please call 410-964-9616 Columbia or 301-774-7501 Olney to schedule your tour.

_____ **Physician Assessment Form –** The physician assessment form should completed and fax'd back to Winter Growth at 410-992-1487 Columbia or 240-389-1017 Olney. We will not be able to complete the admission process until we have received the form.

_____ **PPD/Chest X-ray (Tuberculosis Test) –** Within 90 days prior to admission, a PPD skin test must be administered and read by a registered nurse or physician. The results of this test may be noted on the physician assessment form or on a separate sheet of paper. In lieu of a PPD, a chest x-ray within the last 5 years with no evidence of infectious pulmonary disease is acceptable.

_____ **Assessment –** Next, one of our Social Services staff will contact you to schedule a convenient time to have a personal assessment completed. This assessment ensures that we will be able to meet the needs of each new participant and will also determine their level of care.

_____ **Paperwork –** Prior to starting the program, we will need to have the following forms in hand; Service Contract, Media Release Form, Financial Agreement, Meal Benefit Form, HIPAA Form, Transportation Agreement, if applicable, and a copy of Power of Attorney if applicable. Once these forms are complete, please return them to Social Services.

_____ **Deposit –** When the physician form has been received, assessment has been done, and paperwork has been collected, an enrollment deposit is due prior to the start date. Please contact Social Services to determine the amount of the deposit.

18110 Prince Philip Drive Olney, MD 20832
Phone: 301-774-7501 *Fax:* 240-389-1017
www.WinterGrowthInc.org

5460 Ruth Keeton Way Columbia, MD 21044
Phone: 410-964-9616 *Fax:* 410-992-1487
www.WinterGrowthInc.org

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Physician's Assessment and Order Form

Date_____ Name of Participant_____

DOB_____ Social Security Number_____

Date of last exam_____

Cognition:

Is this person oriented to:	☐Person	☐Place	☐Time	
Disorientation:	☐Never	☐ Mild	☐ Moderate	☐ Severe
Impaired recall: Recent	☐Never	☐ Occasional	☐ Regular	☐ Continuous
Impaired recall: Distant	☐Never	☐ Occasional	☐ Regular	☐ Continuous
Impaired judgment:	☐Never	☐ Mild	☐ Moderate	☐ Severe

Do any of the following apply:

Depression	☐Never	☐ Mild	☐ Moderate	☐ Severe
Anxiety	☐Never	☐ Occasional	☐ Regular	☐ Continuous
Hostility/combativeness	☐Never	☐ Occasional	☐ Regular	☐ Continuous

Is there evidence of:

Behavior disorder_____

Infectious disease_____

Speech deficit? _____

Bowel/bladder incontinence? _____

History of seizures? _____

History of alcohol abuse or drug addiction? _____

History of falls? _____

Mobility: ☐Independent ☐With supervision ☐One person physical assistance

☐Two person physical assistance, or complete mechanical assistance (e.g., Hoyer lift)

Allergies: List any allergies or sensitivities to foods, medications or environmental factors, and (if known) the nature of the problem (rash, anaphylactic reaction, GI symptoms, etc)

_____

THIS PERSON MUST BE CERTIFIED TO BE FREE FROM COMMUNICABLE TUBERCULOSIS

By either PPD Skin Test within **Last Three Months** or Chest X-Ray within **Last 5 Years**

1. PPD_____ mm redness and ____mm induration Date read_____

Or

2. Chest X-ray result_____ Date read _____

****

Recent Hospitalizations:

Date: _____Reason: _____

Date: _____Reason: _____

Date: _____Reason: _____

Name of Participant_____

Blood Pressure_____ Pulse _____ Weight_____ Height_____

Monitoring of nutritional or hydration status necessary? ☐No ☐Yes-explain_____
_____

Recommended Diet:
☐Regular ☐No Added Salt ☐Limited Concentrated Sweets ☐Limited K+ ☐Vegetarian

☐ Mechanical Soft ☐Thick Liquids ☐No Pork ☐No Shellfish ☐Dietary Supplement(s)

Regular diets are low salt, low in saturated fat, trans fat free, high in whole grains, and meet State guidelines. Limited Concentrated Sweets (LCS) and Limited K+ diets are as defined in the State Diet Manual, but are NOT *individually calculated* diabetic and renal diets. Day participants receive one meal and 2 snacks per day at the center.

	System	Normal	Abnormal	Comments
1.	Vision	_____	_____	_____
2.	Hearing	_____	_____	_____
3.	Skin	_____	_____	_____
4.	Appendages	_____	_____	_____
5.	Cardiovascular	_____	_____	_____
6.	Respiratory	_____	_____	_____
7.	Endocrine	_____	_____	_____
8.	Gastrointestinal	_____	_____	_____
9.	Musculoskeletal	_____	_____	_____
10.	Genitourinary	_____	_____	_____
11.	Hematological	_____	_____	_____
12.	Neurological	_____	_____	_____
13.	Psychological	_____	_____	_____

Diagnosis (es)_____
_____
_____

Please indicate any restrictions on physical activities for this person:
_____
_____

Does this person have Advanced Directives for Healthcare ? _____

Please indicate any needed monitoring or performance of tests after admission:_____
_____

Is this person capable of self-medicating? _____

Name of Participant_____

Medications: (Please list dosage, frequency, and precautions. Include over the counter drugs.)

_____

_____

_____

_____

_____

_____

_____

_____

Medication orders in affect for 180 days.

Would you like your patient to be evaluated and treated by **PT**, **OT**, or **Speech**?
(If **yes**, circle applicable therapies.)

Would you like your patient to participate in a base-line assessment in **PT**, **OT**, or **Speech**?
(If **yes**, circle applicable therapies.)

I (DO) (DO NOT) believe that an Adult Day Center is the appropriate placement for this person. Your staff should be alert to the following symptoms and respond according to my directions: _____

_____

_____

This person requires Medical Adult Day Programming (Please circle: 1 2 3 4 5) days per week.

Signed_____Date_____

Print Physician Name_____

Address_____

_____

Phone_____

Montgomery County
18110 Prince Philip Drive
Olney, Maryland 20832
301-774-7501
301-774-2687(fax)

Howard County
5460 Ruth Keeton Way
Columbia, Maryland 21044
410-964-9616
410-992-1487 (fax)

Physician's Agreement

I agree to provide direction to Winter Growth Adult Medical Day Program nursing staff regarding the care of my patient, _____. I have a licensed physician on call who will provide this direction should the agency need it in my absence. I agree to direct Winter Growth's nursing staff in the event of an emergency situation with my patient. I understand that should a life-threatening event occur, the agency will call 911 and have my patient transported to the nearest hospital.

_____	_____	_____
Physician Signature	License Number	Date

Winter Growth, Inc.-Financial Policies

Assisted Living Program

Winter Growth requires an enrollment deposit of 50% of the monthly fee at the Level 3 rate and also the first month's rent prior to moving into the facility. IF an individual moves into the facility before the1st day of the month, an additional payment will be expected for each day before the beginning of the first full month. (ie: move in on April 21 then an additional 10 days of payments will be added to the total due upon admission). Any payments in excess of actual charges shall be refunded to the payor within one month of termination of services.

Adult Daycare Program

Winter Growth requires an enrollment deposit equal to the average charge for one month of the required service scheduled. This deposit will be applied to any outstanding charges for the last month of services and payments in excess of actual charges shall be refunded to the payor within one month of termination of services.

Credit for absences IS NOT given. If an individual is absent due to an illness, vacation, or appointment, Winter Growth will not give a credit for the absence. The only exception to this policy is for day participants who are admitted to the hospital for more than two days. IF Winter Growth receives verification of admission into a hospital for over two days, then the participant will be temporarily discharged after two days. If the participant does not return then all overpayments will be refunded within thirty days' notice of termination of services.

Winter Growth allows for up to two "exchange days" per month, whereby participants may exchange existing scheduled days for newly unscheduled days, subject to availability of an opening on the desired day and the availability of transportation (if this service is also needed). Exchange days due to all absences except hospitalization MUST be used within one month of the absence.

Termination of Services

Anyone desiring to terminate their services with Winter Growth must contact the administrative staff as soon as an individual is no longer able to attend our programs. All notifications should be in writing, to include email notification. Until this notification is received the participant/resident will be responsible for ALL missed days.

Processing and Late Fees

Winter Growth is entirely financially dependent on fees paid for our services. For Winter Growth to maintain financial viability, it is critical that fees be paid no later than the **due date indicated on the invoice.** A late fee of $25 will be assessed for payments not received by the due date. In addition, invoices that require a special format due to **long-term care insurance requirements** will be charged a monthly $25 processing fee.

Short-term Residential Care Prepayments and Cancellation Fees

All overnight respite reservations must pay the full fee upfront unless funded by a third party. A $25 per day cancellation fee is required for reservations cancelled less than fifteen (15) days prior to the scheduled arrival date.

Missing or Damaged Personal Items

Winter Growth is not liable for any missing or damaged personal items.

Commitment of Responsible Party

I _____ agree to be the guarantor for all charges incurred by _____
(Participant/Resident)
unless Winter Growth receives written confirmation that charges will be covered by a third party funding source. I have read and I understand Winter Growth's Financial Policy as set forth above and agree to abide by all of the terms and conditions set forth herein. Notification of any changes to this policy will be mailed at least 45 days prior to becoming effective.

Date: _____ Signature of Responsible Party: _____