DAILY LIVING CENTERS
ADULT DAY SERVICES
Celebrating 50 Years 1974 2024

Bethany Center ☐	South Center ☐	Edmond Center ☐
3000 N Rockwell Ave Bethany, OK 73008 O: (405) 792 – 2401 F: (405) 792 – 2405 www.dlcok.org	1681 SW 86th Street OKC, OK 73159 O: (405) 688 - 5388 F: (405) 688 - 5389 www.dlcok.org	2600 E 2nd Edmond, OK 73034 O: (405) 471 - 6867 F: (405) 906 - 3251 www.dlcok.org

Participant Intake Information

Name: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Phone: (_____) _____ - _____

Social Security Number: _____ - _____ - _____

Birthdate: _____/_____/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race You Consider Yourself:

☐ White ☐ Black/African American ☐ Native American ☐
Hispanic ☐ Asian or Pacific Islander ☐ Other

Living Arrangements: ☐ Independent ☐ With Caregiver

FOR CENTER USE ONLY

DNR: ☐ Yes ☐ No

Inquiry Date/Time: _____

Start Date: _____/_____/_____ Discharge Date: _____/_____/_____

Days: ___M ___T ___W ___TH ___F

Payment: ___PP ___VA ___DHS ___ADV ___DDS ___SCH ___INS

Transportation: ___Family ___DLC ___Other

MEDIA: ☐ Yes ☐ No

MEAL: ___Free ___Reduced ___Ineligible

Physician: _____ **Hospital Preference:** _____

Physician's Phone: (_____) _____ - _____ **Physician's Fax:** (_____) _____ - _____

RESPONSIBLE PARTY:

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ **Cell Phone:** _____ Work Phone: _____

E-mail: _____ ☐ Subscribe to Newsletter

PRIMARY EMERGENCY CONTACT:

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ **Cell Phone:** _____ Work Phone: _____

E-mail: _____ ☐ Subscribe to Newsletter

OTHER EMERGENCY CONTACTS:

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: ____ Zip: ___

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

E-mail: _____ ☐ Subscribe to Newsletter

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ **Cell Phone:** _____ Work Phone: _____

E-mail: _____ ☐ Subscribe to Newsletter

I learned about the Daily Living Centers from: ☐ Social Media ☐ Newspaper ☐ Friend ☐ United Way ☐ Family Member ☐ Physician ☐ Other: _____

DAILY LIVING
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Consent for Release of Confidential Information

Name: _____

Social Security Number: _____

Date of Birth: _____/_____/_____

Your patient, identified above, is interested in attending the Daily Living Centers, Inc., a non-profit organization striving to promote independent functioning and social needs of older and disabled citizens.

By state law, you must be advised that:

The information authorized for release may include records indicating the presence of a communicable or venereal disease. The diseases may include, but are not limited to, hepatitis, syphilis, gonorrhea, and the Human Immuno-deficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I, _____ hereby give consent to Dr. _____ (personal physician) and to _____ (hospital/facility) to release health information to the Daily Living Centers, Inc. so the Center might be informed to assist with my health care. I understand this consent can be revoked at any time, **except to the extent that disclosure made in good faith has already occurred in reliance on this consent**. All employees, officers, attending physicians, and physicians listed above are released from legal responsibility for the release of the requested information.

Dated this _____day of _____, 20____.

_____
Signature of Participant/Guardian/Representative

_____
Signature of Witness

DAILY LIVING CENTERS
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Please return or fax to:

- ☐ Bethany Fax 405-603-3709
- ☐ South OKC Fax 405-688-5389
- ☐ Edmond Fax 405-906-3251

Physician's Orders

Please complete the entire form as legibly as possible.

Participant: _____
SSN (last 4): _____
Date of Birth: _____
Date of Last Physical Assessment: _____

Physician's Name: _____
Physician's Address: _____
_____
Physician's Phone: _____
Physician's Fax: _____

List of All Diagnoses:

Weight & vital signs, monthly unless otherwise stated: _____
Test blood sugar monthly (diabetics) unless otherwise stated: _____
Other treatments including oxygen or breathing treatments: _____
Is there a DNR order? ☐ Yes ☐ No
Allergies to medications or foods: _____

Medications including OTC meds: (please include dosage, frequency, route and reason)

My patient may have any of the following on a PRN basis per directions on package: (Please check)
☐ Acetaminophen 500mg ☐ Ibuprofen 200mg ☐ Antacid ☐ Barrier cream ☐ Cough drops

Dietary needs (please check all that apply):
☐ General or regular diet ☐ Low concentrated sweets (LCS) ☐ No added salt

My patient may receive wound care with soap and water for cuts and scrapes: ☐ Yes ☐ No

May participate in group chair exercises? ☐ Yes ☐ No Activity level: _____

Signature of Physician **Date**

DAILY LIVING CENTERS
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Safety Assessment Worksheet

Completed by Family

Participant's Name: _____ **Date:** _____

1. Are you having difficulty buttoning buttons or snaps on clothing?	☐ Yes	☐ No
2. Do you require assistance when getting dressed?	☐ Yes	☐ No
3. Have you noticed a decrease in your arm strength?	☐ Yes	☐ No
4. Are you having difficulty lifting or raising your arms over your head?	☐ Yes	☐ No
5. Are you having difficulty holding kitchen utensils or feeding yourself?	☐ Yes	☐ No
6. Are you having difficulty maintaining your balance while standing, washing, or putting dishes away, or brushing your teeth at the sink?	☐ Yes	☐ No
7. Have you recently experienced a decrease in strength, endurance/stamina, or mobility?	☐ Yes	☐ No
8. Are you having difficulty speaking and communicating your needs?	☐ Yes	☐ No
9. Is it difficult to sit on the edge of your bed without falling toward one side or the other?	☐ Yes	☐ No
10. Are you having difficulty getting in and out of your bathtub?	☐ Yes	☐ No
11. Do you have difficulty getting in and out of bed?	☐ Yes	☐ No
12. Are you having difficulty walking or have you had falls recently?	☐ Yes	☐ No
13. When walking, do you require assistance from a walker, cane, etc.?	☐ Yes	☐ No
14. If currently using an assistive device, do you have difficulty getting in/out of a chair?	☐ Yes	☐ No
15. Do you have difficulty using your assistive device?	☐ Yes	☐ No
16. If you use a wheelchair, do you have difficulty transferring to or from your bed, recliner, toilet, etc.?	☐ Yes	☐ No

_____ _____

Signature of Participant / Guardian / Representative **Date**

DAILY LIVING
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Participant Medical History

Completed by Family

Name:_____

Diagnoses: (please list)

Medications: (please list)

Past Surgeries: (please list)	**Date:**	**Allergies:** (please list)

Weight Loss or Gain in the last 6 months? ☐Yes ☐No

Is there a DNR (Do Not Resuscitate) Order? ☐Yes ☐No

Have you ever experienced any of the following health problems? (Check all that apply)

☐ Diabetes	☐ Depression	☐ Heart Disease	☐ Heart Attack
☐ Heart Failure	☐ Dementia	☐ Stroke	☐ Inability to Speak
☐ Chronic Lung Disease	☐ High Blood Pressure	☐ Pneumonia	☐ Memory Problems
☐ Stomach Problems	☐ Paralysis	☐ Bowel Problems	☐ Joint Pain/Arthritis
☐ Parkinson's Disease	☐ Urinary Infections	☐ Diarrhea	☐ Pacemaker
☐ Dizziness	☐ Osteoporosis	☐ Incontinence	☐ Fractures
☐ Multiple Sclerosis	☐ Seizures	☐ Skin Problems	☐ Anemia
☐ Headaches	☐ Constipation	☐ Head Injuries	☐ Thyroid Problems
☐ Kidney Problems	☐ History of Alcoholism	☐ Combativeness	☐ Smoking

☐ Cancer - Please Specify: _____

☐ Hernias - Please Specify: _____

☐ Behavioral Problems: _____

☐ Other Case Problems:

Reviewed by: _____ **Date** _____

DAILY LIVING CENTERS
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Participant Financial Information

Participant's Name: _____

Participant's Gross Monthly Income: _____

Combined Income (If Married/Separated): _____

RESPONSIBLE PARTY:

Name: _____ Relationship: _____

_____

Street Address: _____ City: _____ State:____ Zip:_____

DHS Information for Participant:

Eligible for DHS Assistance: ☐ **Yes** ☐ **No**

Date Filed for DHS Assistance: _____

DHS Case Number: _____

Number of Days / Month Approved:

Case Worker: _____

_____

Co-Pay: _____

Medicaid/SoonerCare Number: _____

Long Term Care Insurance:

Company Name:_____ Policy Number: _____

Veteran: ☐ **Yes** ☐ **No** **Legal Oklahoma Resident:** ☐ **Yes** ☐ **No**

CHECK ALL THAT APPLY: (Provide Copies of Each)

☐ Living Will ☐ Power of Attorney ☐ Durable Power of Attorney

☐ Conservator ☐ Guardian ☐ Do Not Resuscitate

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Agreement to Pay

I agree to attend the Daily Living Centers, Inc. _____ days per week on a regular basis. Participants must attend one (1) day per week minimum and may attend up to five (5) days per week.

I agree to pay the daily rate of **$95.00 or half day** (4 hours or less) **rate of $47.50**. I understand that approvals for the Oklahoma Department of Human Services and ADvantage Waiver Programs will be for a specific number of days per week and if I exceed the approved number of days, I am responsible for payment of those days. **To suspend fee payment for absences exceeding two (2) weeks, I understand a written notice must be provided to the Center one week prior to the actual days of non-attendance.**

I understand that payment is due upon presentation of the monthly bill. Checks are to be made payable to Daily Living Centers, Inc. Checks may be mailed or dropped off at the Center. ***If payment is not received by the 10th day following date of bill, participant can no longer attend Daily Living Centers, Inc. until bill is paid in full.***

For my fee I will receive the following services:

1) Recreational exercises, activities, socialization – both group and individual
2) Nurse monitoring and education to include administration of prescribed medications, health monitoring, initial assessment, etc.
3) Breakfast, lunch, and afternoon snack

For an Additional Fee, the following services are provided:

1) Transportation if needed, within specified geographic locations - $22 / Day
2) Bathing, if available - $12 / Bath

Special Payment Arrangements: _____

_____ _____

Signature of Participant / Guardian / Representative **Date**

_____ _____

Signature of Finance Director **Date**

DAILY LIVING
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Admission Agreement

I understand that my acceptance into the Daily Living Centers, Inc. program is provisional and that I will be evaluated for two weeks by the staff of the Center for appropriateness of this program for me.

In the event of a medical emergency, I will be transported to a hospital while my family is being notified.

Further, I understand that my acceptance into the Daily Living Centers, Inc. program may be terminated following the provisional period for the following reasons:

1) I exhibit behavior(s) that interfere with the operation of the program.

2) I experience a physical or mental condition that indicates another level of care (ex: aggression, full body lift, elopement, etc.).

3) I am a health or safety risk to myself, other participants, staff, or volunteers of the program.

4) **Health or safety risks such as violence or sexual behaviors will be cause for immediate discharge from the program.**

In addition, I understand if I have any habit or behavior that is disruptive to the group, my continuance in the program will depend upon my correction of the problem. I understand that the Daily Living Centers, Inc. and my family will work with me to correct difficulties. Failing improvement, I will receive a two-week written notice and be discharged from the program.

Signature of Participant / Guardian / Representative **Date**

DAILY LIVING
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Rights of Adult Day Health Participants

Participant Name: _____

Each participant of the Daily Living Centers, Inc. shall be assured of the following rights:

1) To be treated as an adult with respect and dignity regardless of race, color, or creed.

2) To participate in a program of services and activities which promote positive attitudes regarding one's usefulness and capabilities.

3) To participate in a program of services designed to encourage learning, growth, and awareness of constructive ways to develop personal interests and talents.

4) To maintain independence, to the extent possible, and to be involved in a program of services designed to promote personal independence.

5) To be encouraged to attain self-determination, including the opportunity to participate in developing one's care plan for services, to decide whether or not to participate in any given activity, and to be involved, to the extent possible, in program planning and operation.

6) To be cared for in an atmosphere of sincere interest and concern in which needed support and services are provided.

7) To have privacy and confidentiality.

8) To be free of mental and physical abuse.

9) To be free of restraint unless under physician's order as indicated in individual care plan.

10) To have access to telephone to make or receive calls unless necessary restrictions are indicated in the individual care plan.

11) To be free of interference, coercion, discrimination, or reprisal.

_____ _____

Signature of Participant / Guardian / Representative **Date**

DAILY LIVING
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Grievance Procedures

Daily Living Centers, Inc. (DLC) has adopted an internal grievance procedure providing an equitable resolution of complaints alleging any action prohibited by the United States Department of Public Health, Section 504 of the Rehabilitation Act of 1973 which states, "no otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Who may file a grievance: Any person receiving services from DLC may file a grievance. Grievances can also be filed by anyone interested in the welfare of a DLC client such as parents, guardian, staff, case manager, caregiver, or advocate.

What complaints are considered: The complaint may be about any policy, rule, decision, behavior, action, or condition made or permitted by DLC, its employees, or other persons authorized to provide care. Grievances against a facility or provider are handled by the facility or provider. Grievances against OKDHS or its staff are handled by the grievance coordinator in your area office.

1) A complaint should be in writing, containing the name, address and phone number of the person filing it, and briefly describe the action alleged.
2) The complaint is to be filed in the office of the Daily Living Centers VP of Operations within a reasonable time after the complaint is alleged. The Director of Operations can be reached at 405-792-2401 or grievance may be mailed to: Daily Living Centers, C/O VP of Operations, PO Box 608, Bethany, OK 73008.
3) The VP of Operations or designee shall investigate of the complaint as may be appropriate to determine its validity. These rules contemplate an informal, but thorough investigation, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the complaint.
4) The VP of Operations or designee shall issue a written decision determining the validity of the complaint no later than 30 days after it has been submitted.
5) The VP of Operations shall maintain the files and records of DLC relating to complaints filed hereunder. The VP of Operations may assist persons with the preparation and filing of complaints, participate in the investigation of complaint, and advise the Grievance Committee.
6) The resolution shall be presented to the named party in writing after review by the VP of Operations and the Grievance Committee.
7) If you are not satisfied with the proposed resolution, you may contact the Oklahoma Department of Health, which is the licensing body of Adult Day Care Centers, at: Director Complaint Investigations Adult Day Care, 1000 NE 10th Oklahoma City, OK 73117-1299 (405) 271-6868
8) Other useful phone numbers: ADvantage Services Consumer Inquiry System (CIS): 1-800-435-4711; DDS: (405) 521-6267; VA: (405) 456-1000

I have received a copy of the grievance procedures from Daily Living Centers of Oklahoma.

Signature of Participant	**Date**
Signature of Guardian / Representative	**Date**

DAILY LIVING
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Release of Responsibility

I would like to attend the Daily Living Centers, Inc. and participate in the regularly scheduled activities. I acknowledge my participation in all activities sponsored by the Daily Living Centers, Inc. is voluntary and will not hold Daily Living Centers, Inc. nor any employee or volunteer responsible for any illness or accidents that may occur while I am a participant in the program. I understand that any financial liability incurred due to transportation, treatment, or extended care which results in an accident or illness while in attendance at the Daily Living Centers, Inc. is my sole responsibility.

Signature of Participant / Guardian / Representative **Date**

Additional Services Agreement

I hereby request to be referred to the following additional services. I understand that I am fully responsible for the cost of such services and that I will be billed separately for these costs by the agency providing the service.

- ☐ Physical, Speech, and/or Occupational Therapy Service
- ☐ Mental Health Counseling Services
- ☐ Home Health Services
- ☐ Hospice
- ☐ No additional services requested

Signature of Participant / Guardian / Representative **Date**

Publicity Release

☐ **I CONSENT** and authorize the use and reproduction of any and all photographs or video taken by the Daily Living Centers, Inc. or its authorized representatives, for the purpose of publicity and agree that there is no monetary compensation transferred. All media shall remain the sole property of the Daily Living Centers, Inc.

☐ **I DO NOT CONSENT** to, **NOR** authorize, the use and reproduction of any photographs or video to be taken of me by the Daily Living Centers, Inc., or its authorized representatives, for the purpose of publicity.

Signature of Participant / Guardian / Representative **Date**

DAILY LIVING
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Release of Participant's Information

I, _____, as the participant or primary caregiver for _____, authorize the Daily Living Centers, Inc. to release Participant information to the following individuals:

_____ Print Name

_____ Print Name

_____ Print Name

_____ Print Name

_____ Print Name

_____ Print Name

I understand that **only** the individuals listed above will be given Participant information. I understand that I am responsible for keeping this list up to date and do not hold the Daily Living Centers, Inc. responsible if I fail to do so.

_____ **Signature of Participant / Guardian / Representative**

_____ **Date**

Leave Authorization

I understand that the participant, _____, will be allowed to leave the Daily Living Centers, Inc. facility with only the following individuals. I understand that I am responsible for keeping this list up to date and do not hold the Daily Living Centers, Inc. responsible if I fail to do so. A Driver License must be presented.

_____ Print Name

_____ Print Name

_____ Print Name

_____ Print Name

_____ Print Name

_____ Print Name

_____ Print Name

_____ Print Name

☐ **I CONSENT** to allow _____ (participant) to leave the Daily Living Centers, Inc. facility of my/their own recognizance.

☐ **I DO NOT CONSENT** to allow _____ (participant) to leave the Daily Living Centers, Inc. facility of my/their own recognizance.

_____ **Signature of Participant / Guardian / Representative**

_____ **Date**

DAILY LIVING
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Consent to Use and Disclosure of Protected Health Information For Treatment, Payment, or Healthcare Operations

Name of Participant: _____

I understand that the Daily Living Centers, Inc. maintains, uses, and discloses personal health information 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 Daily Living Centers, Inc.

I understand that these and other uses and disclosures of my personal health information are described completely in the Daily Living Centers, Inc. Notice of Privacy Practices.

I understand that the Daily Living Centers, Inc. reserves the right to change its privacy practices described in the Notice of Privacy Practices at any time and to make the new notice provisions effective for all protected health information already received and any new information required or maintained by the Daily Living Centers, Inc. I understand that prior to implementation, the Daily Living Centers, Inc. will mail a copy of the revised Notice of Privacy Practices to the address I have provided.

In addition, I understand that I have the following rights:

- The right to receive and review the Daily Living Centers, Inc. Notice of Privacy Practices before signing this Consent.
- The right to request restrictions on how protected health information about me is used or disclosed for treatment, payment or health care operations. The ***Center*** 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 Daily Living Centers, Inc. 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 the Daily Living Centers, Inc. 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.

Signature of Participant / Guardian / Representative	**Date**
Signature of Witness	**Date**

DAILY LIVING
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Participant Demographic and Interests

Please tell us as much about yourself as possible for us to plan programs and activities that interest and benefit you.

Name: _____ **Spouse's Name:** _____

Maiden Name: _____ **Years Married:** _____

Birthdate: _____ **Location Married:** _____

Place of Birth: _____ **Number of Children:** _____

Names of Children: _____

Places Lived: _____

Places Traveled: _____

Occupation(s): _____

Primary & Secondary Language(s): _____

High School & College(s) Attended: _____

Activities of Interest:

☐ Arts/Crafts	☐ Games	☐ Museums	☐ Puzzles	☐ Sports
☐ Cooking	☐ Gardening	☐ Music	☐ Reading	☐ Television
☐ Exercise	☐ Movies	☐ Pets/Animals	☐ Shopping	☐ Walking

Religious Preference: _____ **Church:** _____

Clubs/Organizations/Volunteer Work: _____

Veteran: ☐ Yes ☐ No

Living Arrangement: ☐ Self ☐ With Caregiver

DAILY LIVING
CENTERS
ADULT DAY SERVICES

Information for Responsible Parties and Caregivers

Hours of Operation

Bethany Center	Edmond Center	South OKC Center
6:30 am to 5:30 pm, M-F Closed Saturday & Sunday & Major Holidays	7:00 am to 5:30 pm, M-F Closed Saturday & Sunday & Major Holidays	7:00 am to 5:30 pm, M-F Closed Saturday & Sunday & Major Holidays

Daily Living Centers, Inc. Adult Day Health Program

Initials _____

The Daily Living Center has a total of three facilities located in Bethany, Edmond, and South Oklahoma City. We are committed to providing the highest quality adult day health care with opportunities for social interaction to promote health and wellness to those who may require a more structured and protective environment.

Our adult day health care programs offer services like health and fitness, medical monitoring, activities, nutritious meals and snacks, community integration opportunities, caregiver support group meetings, door-to-door limousine and van transportation while promoting self-efficacy. Our program is designed to provide daytime care for adults who have limited physical and mental disabilities, including those needing special attention, such as those with dementia or Alzheimer's disease. We provide a safe, secure environment and by law maintain a 1 staff person to 8 participant ratios. Scheduled activities are planned monthly and may include mild physical exercise, games to stimulate the mind, arts and crafts, karaoke, pet therapy, and bingo to name a few.

Attendance

Initials _____

Participants must attend a minimum of 1 day per week, but most attend from 3-5 days per week. A participant, caregiver or other responsible family member is expected to notify the Daily Living Centers, Inc. at least **24 hours in advance** to cancel scheduled attendance of a participant. If you want to bring your loved one on a day they are not regularly scheduled and they will be eating lunch, we need to know **the day before** in order to have enough food on hand. **The responsible party will be charged $5.00 per minute late fee for every minute late picking up their participant after the above stated hours.**

DAILY LIVING
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Information for Responsible Parties and Caregivers

Initials

Medication

Daily Living Centers, Inc. must have a Physician's Order on file to administer medication. There is a nurse on duty at each individual Center. The nurse can dispense medications during the day; however, prescription medicine will be dispensed ONLY from bottles issued by the pharmacy. These bottles must have the most current date and be correctly labeled with the participant's name, correct dosage, and time(s) to be given. A minimum two (2) week supply of medication is expected, if appropriate.

When the supply is depleted, the bottle will be sent home with the participant to be refilled. Please return the medications in the NEW CONTAINER to the Nurse in charge. Any medications, which have been changed or discontinued, must be reported to the Center nurse IMMEDIATELY!

To discuss medicines or medical information, call the Center and ask for the nurse. NO OVER THE COUNTER DRUGS, including Tylenol, will be given without a Physician's Order. All over the counter drugs must be furnished by the participant/caregiver and must be in their original container.

We cannot and will not accept or dispense medications from containers other than the above. This is a requirement of the State Health Department for licensure, and it also meets the requirements of the Nurse Practice Act.

Initials

Physician's Orders

We must have Physician's Orders prior to the first day of attendance. Please see the nurse if you need help obtaining the Physician's Order. The signed Physician's Order form must be renewed yearly. Participants who have changed or added/deleted physicians are asked to notify the nurse at the Center so current orders can be obtained.

Initials

Illness

If participants who become sick or exhibit signs of sickness, health concerns, or any other illness while in the care of the Daily Living Centers, Inc. will be sent home or to the hospital on the evaluation and recommendation of the nurse. Participants who have a temperature of 99.4 will not be allowed to remain at the Center. PLEASE DO NOT bring them to the Center as they will be sent home immediately. Participants that have displayed symptoms of illness should remain at home until they are symptom free for 24 hours. Please inform the staff if a participant has been ill overnight, over the weekend, or if the participant has recently entered or been discharged from the hospital or another facility. This requirement is in place to protect all participants as well as staff from spreading illness. Also, draining lesions or open wounds are required to be covered by bandage or dressing prior to attending the Center.

Initials

Right to Access Personal Records

By request, all participants and designated family members can access their personal medical and financial documents at any time. Please contact the Center Director 48 hours prior to needing access.

DAILY LIVING
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Adult Day Health Care Payment Programs

Daily Living Centers, Inc. accepts the following pay sources:

Private Pay

Private pay fees are **$95.00 full day or $47.50 half day** (4 hours or less). per day for Adult Day Health Care. An additional $22.00 per day will be charged if Daily Living Center transportation services are needed/required.

Daily Living Centers, Inc. Social Services Director can provide assistance with any of the following pay sources application processes. Please contact them at (405) 792-2401 or info@dlcok.org.

DHS

Oklahoma Department of Human Services (DHS) has an Adult Day Health Care financial assistance program for qualified individuals. Individuals 18 years of age and older who receive less than $2083 per month may qualify to receive Adult Day benefits. The purpose of this program is to offer the participant's caregiver to receive education, training, look for employment, work, and/or to provide the elderly participant social development activities and to prevent institutionalization.

ADvantage Program

ADvantage provides non-institutional long-term care services through the Medicaid program to help functionally impaired elderly persons and adults with physical disabilities remain in their own homes as long as possible. Persons must qualify both financially and medically to be determined eligible for ADvantage Services. Services are based on individual needs and can include case management, skilled nursing, personal care, adult day care/respite, as well as other services. Qualification standards are based on monthly GROSS income less than $2,250 with other qualifying details.

Department of Veterans Affairs

The Department of Veterans Affairs (VA) program provides assistance with a variety of services that include Adult Day Health Care programs.

DAILY LIVING
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ADULT DAY SERVICES

Adult Day Health Care Payment Programs

Continued

Respite Vouchers

Respite vouchers are monetary vouchers to offset the cost of providing care and allowing care givers time to shop, go to appointments, or simply rest. Vouchers may be used to pay individual sitters or help with adult day services. Respite vouchers may be obtained through the following:

OU Sooner Success
Contact: Robyn Boswell (405) 271-5700 X 47801
For primary care givers of individuals under sixty (60) years of age. Vouchers valuing $400 will be distributed quarterly to those who qualify. The eligibility income limit is $90,000 per year.

Areawide Aging Agency, Inc.
Contact: Terry Mulkey (405) 321-3200
For full-time caregivers of individuals over sixty (60) years of age who need assistance in two (2) or more areas or any age and have a diagnosis of Alzheimer's Disease or dementia. Vouchers valuing $300 will be distributed quarterly to those who qualify. (Caregiver may not work outside the home.)

You will not be eligible for these programs if you are currently enrolled with DHS, ADvantage, or DDS.

Credit Card Payments

The Daily Living Centers, Inc. accepts Visa and MasterCard payments. If you are interested in this, please contact the Finance Office at (405) 792-2401.

DAILY LIVING
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Holidays

Daily Living Centers, Inc. will be closed on the following days:

New Year's Day

Martin Luther King Jr Day

Memorial Day

Independence Day

Labor Day

Thanksgiving Day &

Friday following Thanksgiving Day

Christmas Day

Signature of Participant / Guardian / Representative **Date**

DAILY LIVING
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Caregiver Support Groups

Connect with caregivers to discuss the unique challenges and services tailored to both senior and young adults as they navigate the aging journey. Discover the incredible support, guidance, and sense of community our caregiver support group provides, offering a space to share experiences, find resources, and feel truly understood.

3rd Thursday monthly at 6:00 pm via Zoom.

Our support groups are always open to caregivers and loved ones. For information or to register, please contact Jessica Arreola, Director of Social Services, at Jessicaa@dlcok.org or (405) 792-2401.

DAILY LIVING
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Outings Permission Form

Choose one

I, _____, give Daily Living Centers, Inc. permission to transport.

_____ (participant) on outings whenever weather and conditions permit them to do so. These outings will include trips to the lake, parks, civic and cultural centers and other places of interest in and around the Oklahoma City Metro area.

I, _____, **DO NOT** give Daily Living Centers, Inc. permission to transport _____ (participant) on outings or field trips due to health and safety concerts.

_____ _____

Signature of Participant / Guardian / Representative **Date**

In case of emergency, please notify:

Name: _____

Relationship: _____

Phone Number: _____

United Way of Central Oklahoma

LIVE UNITED United Way

Photo Release Form

I hereby give United Way of Central Oklahoma permission to take photographs and/or video footage of me and to publish in print, electronic, audio, or video format the likeness or image of me. I release all claims against the United Way of Central Oklahoma with respect to copyright ownership and publication including any claim for compensation related to use of the materials. I understand that when images are published, United Way of Central Oklahoma will provide minimal identifying information which may include my name but not my, street or mailing addresses, e-mail addresses, or phone numbers.

I am 18 or older. I have read the above statement and fully understand its contents.

-or

I am the parent/guardian of a minor child. I have read the above statement and fully understand its contents.

YOUR NAME (Please print)_____

YOUR SIGNATURE _____

DATE _____

CELL PHONE NUMBER _____

ORGANIZATION/COMPANY_____

CHILD'S NAME (Please print) _____

YOUR NAME (Parent or Guardian, Please print)_____

YOUR SIGNATURE _____

DATE _____

Effective June 2012
Approved by Legal Counsel