ALPS Adult Day Services

Participant Registration Form

name: _____ phone: _____

street: _____ city: _____ state: _____ zip: _____

date of birth: _____ age: _____ Social Security number: _____ marital status: _____

religion: _____ date enrolled: _____

primary caregiver's name: _____ relationship: _____

street: _____ city: _____ state: _____ zip: _____

occupation: _____ employer: _____ work phone: _____

home phone: _____ cell phone: _____ other: _____

e-mail address: _____

person responsible for payment: _____

address (if different from above): _____

Please list at least two people we could contact in the event of an emergency if the caregiver cannot be reached. These phone numbers must be current; please let us know if any changes occur.

name: _____ relationship: _____ phone: _____

Additional number(s) for this contact: _____

name: _____ relationship: _____ phone: _____

Additional number(s) for this contact: _____

participant's primary physician: _____ phone: _____

other physician(s): _____

preferred Morristown hospital (please circle*):* *Lakeway Regional Hospital* or *Morristown-Hamblen Healthcare System*

names of persons who are authorized to pick up participant from ALPS:

_____

_____

Please read the following statement, then sign and date below.

In the event of an emergency, I give permission for _____ to be transported to the nearest emergency room or to my preferred hospital (depending upon the nature of the emergency). I understand that I am responsible for all charges resulting from the emergency care, including ambulance or rescue squad charges. I also give permission for ALPS staff to provide emergency medical personnel with any information which will assist them in treatment of the emergency.

caregiver's signature: _____ date: _____

caregiver's name (printed): _____

***Please provide ALPS with copies of the participant's Social Security card, insurance card(s), and Medicare card which we will keep on file in the event of an emergency.**

ALPS Adult Day Services

Medical History Form

Dear Physician:

Your patient is applying for enrollment at ALPS Adult Day Services. The information you provide will help ensure that he/she is given appropriate care and services while at our facility. This information will also serve in providing current medical history in the event of an emergency. Information provided on this form is confidential and will only be released with written authorization. Please attach any pertinent test results to this form. Thank you for your assistance.

---

name: _____ date of birth: _____ sex: _____

street: _____ city: _____ state: _____ zip: _____

date of last physical exam: _____ weight: _____ blood pressure: _____

date and results of last chest x-ray: _____

date and result of last TB test: _____

date and result of last auditory exam: _____

date and result or last visual exam: _____

Does this person require (circle): *glasses* *hearing aid* *walker* *cane* *wheelchair*

DIAGNOSIS:

primary: _____

secondary: _____

ALLERGIES:

food: _____

medication: _____

other: _____

PHYSICIAN'S ORDERS:

medications: _____

_____

dietary: Regular ❑ No Sugar Added ❑ Diverticulosis ❑

physical limitations: _____

recommendations/comments: _____

_____

I have reviewed the health history of this person and find him/her able to participate at ALPS.

Physician signature: _____ ***date:*** _____

ALPS Adult Day Services

Participant Prescription and Nonprescription Medication Form

Participant name: _____start date: _____

1. medication: _____ dose/frequency: _____
   specific time(s): _____ start date: _____ purpose: _____

2. ***medication: _____ dose/frequency: _____***
   specific time(s): _____ start date: _____ purpose: _____

3. medication: _____ dose/frequency: _____
   specific time(s): _____ start date: _____ purpose: _____

4. ***medication: _____ dose/frequency: _____***
   specific time(s): _____ start date: _____ purpose: _____

5. medication: _____ dose/frequency: _____
   specific time(s): _____ start date: _____ purpose: _____

6. ***medication: _____ dose/frequency: _____***
   specific time(s): _____ start date: _____ purpose: _____

7. medication: _____ dose/frequency: _____
   specific time(s): _____ start date: _____ purpose: _____

8. ***medication: _____ dose/frequency: _____***
   specific time(s): _____ start date: _____ purpose: _____

9. medication: _____ dose/frequency: _____
   specific time(s): _____ start date: _____ purpose: _____

10. ***medication: _____ dose/frequency: _____***
    specific time(s): _____ start date: _____ purpose: _____

11. medication: _____ dose/frequency: _____
    specific time(s): _____ start date: _____ purpose: _____

12. ***medication: _____ dose/frequency: _____***
    specific time(s): _____ start date: _____ purpose: _____

ALPS Adult Day Services

Participant Prescription and Nonprescription Medication Form

13. medication: _____ dose/frequency: _____
    specific time(s): _____ start date: _____ purpose: _____

14. ***medication:*** **_____** ***dose/frequency:*** **_____**
    specific time(s): **_____** ***start date:*** **_____** ***purpose:*** **_____**

15. medication: _____ dose/frequency: _____
    specific time(s): _____ start date: _____ purpose: _____

16. ***medication:*** **_____** ***dose/frequency:*** **_____**
    specific time(s): **_____** ***start date:*** **_____** ***purpose:*** **_____**

17. medication: _____ dose/frequency: _____
    specific time(s): _____ start date: _____ purpose: _____

18. ***medication:*** **_____** ***dose/frequency:*** **_____**
    specific time(s): **_____** ***start date:*** **_____** ***purpose:*** **_____**

19. medication: _____ dose/frequency: _____
    specific time(s): _____ start date: _____ purpose: _____

20. ***medication:*** **_____** ***dose/frequency:*** **_____**
    specific time(s): **_____** ***start date:*** **_____** ***purpose:*** **_____**

21. medication: _____ dose/frequency: _____
    specific time(s): _____ start date: _____ purpose: _____

22. ***medication:*** **_____** ***dose/frequency:*** **_____**
    specific time(s): **_____** ***start date:*** **_____** ***purpose:*** **_____**

ALPS Adult Day Services

PHOTO RELEASE FORM

participant name: _____ start date: _____

I hereby give permission for the ALPS Adult Day Center staff and/or a designated volunteer to:

(*check each box to which you agree)

☐ Take a photograph of my loved one

☐ Videotape my loved one

☐ Record my loved one's voice

☐ Use my loved one's artwork (or a reproduction thereof)

Furthermore, I authorize the use and reproduction of these for publicity and/or educational and/or informational purposes without compensation to me or to my family member. All copies and negatives shall constitute the property of ALPS Adult Day Services.

caregiver signature: _____ date: _____

caregiver name (printed): _____ date: _____

witness signature: _____ date: _____

*Please note: Failure to agree to any other items on this release form WILL NOT affect your loved one's participation in the program.

ALPS Adult Day Services

Waiver of Liability

participant name: _____ start date: _____

I hereby give permission for my family member to participate in the ALPS activities described below. I will not hold any of the ALPS staff, volunteers, or Board members responsible for any injury to the above-named participant which occurs during any of the activities listed below:

- daily activities at the ALPS Center
- administration of prescription medication as prescribed by the participant's physician (Medications must be brought to the center in a labeled, duplicate prescription bottle.)
- administration of nonprescription medications as requested by the participant's family (Medications must be brought to the center in their original containers.)

caregiver signature: _____ date: _____

caregiver name (printed): _____ date: _____

witness signature: _____ date: _____

ALPS Adult Day Services

Policies and Admissions Agreement

participant name: _____ start date: _____

1. Hours to be spent at the Center will be based upon the participant's ability level and family need. Hours will be approved by the Executive Director and will be reviewed as the participant's ability level changes.
2. Days to be spent at the Center will be based upon the participant's ability level and family need. Three to five days per week is recommended but not mandatory in order for the participant to remain adjusted to the program and to receive maximum benefits from the Center's activities.
3. Center hours are from 7:30 a.m. to 5:30 p.m. (with some exceptions). **Late pick-up charges are $5.00 *for each minute* past 5:30 p.m. INITIAL: _____**
4. ALPS must have *two* current emergency numbers on file at all times.
5. Transportation to the Center is provided by the participant's family or other caregiver who will escort the participant into the appropriate activity room or reception area.
6. Prescription medications must be brought to or kept at the Center in a duplicate prescription bottle. Nonprescription medications must be in their original container. Medications will be stored in a locked secure area, and participants may not have medication in their possession at *any* time.
7. Participants must have had a physical exam within three months prior to enrollment. In the event of an emergency, the preferred Morristown hospital (as indicated on the registration form) will be used.
8. Ongoing family/caregiver involvement is essential. Families are encouraged to attend special events, caregiver classes, and support group meetings.
9. A family member/caregiver will give the Center **24-hour notice** if the participant is unable to attend on a scheduled day, at which time an alternate day may be scheduled. **Participants will be charged the full fee of $60.00 for absences without notification. INITIAL: _____**
10. Participants may be suspended or terminated from the program for: (1) behavior which is severely disruptive to activities; (2) behavior which places other clients, staff members, or others in danger; (3) change in medical status which cannot be managed at the Center; (4) communicable diseases; (5) failure of participant's family/caregiver to adhere to Center policies; and (6) failure to pay fees.
11. Participants with infectious disease or illness (such as vomiting or diarrhea) are not allowed to attend the Center. Anyone who becomes ill or who is injured at the Center must be picked up by a family member/caregiver within one hour of notification by staff. A physician's release must be obtained and on file at ALPS prior to the participant's re-entering the program.
12. Scheduled days on which ALPS will be closed will be posted on the Center door. The Center may also close for severe weather conditions, at which time a message will be left on the Center's answering machine.
13. Video monitoring of clients and activities may be utilized at times to ensure client safety, as well as to allow caregivers the opportunity to observe their loved one as he/she participates in the program.
14. **Payment is expected within 15 days of receipt of invoice. A late fee of $15.00 may be charged if payment is not received within this time period. INITIAL: _____**

****

I have read, understood, and agreed to the above ALPS policies:

caregiver signature: _____ date: _____

ALPS Adult Day Services

Participant Activities of Daily Living

participant name: _____ start date: _____

ACTIVITY	INDEPENDENT	NEEDS HELP	UNABLE TO DO
Dressing			
tie shoes	❑	❑	❑
slip-on shoes	❑	❑	❑
socks/stockings	❑	❑	❑
buttons	❑	❑	❑
zippers	❑	❑	❑
Personal Hygiene			
bathing him/herself	❑	❑	❑
teeth/denture cleaning	❑	❑	❑
brushing/combing hair	❑	❑	❑
shaving	❑	❑	❑
toileting	❑	❑	❑
Movement			
in and out of car	❑	❑	❑
rising from chair	❑	❑	❑
walking on level surface	❑	❑	❑
stairs	❑	❑	❑
Eating			
feeds him/herself	❑	❑	❑
cuts meat	❑	❑	❑
knows utensils	❑	❑	❑
prepares a sandwich	❑	❑	❑

ACTIVITY	NEVER	SOMETIMES	ALWAYS
sleeping problems	❑	❑	❑
wandering	❑	❑	❑
suspiciousness	❑	❑	❑
confusion	❑	❑	❑
repetitious questions	❑	❑	❑
disorientation	❑	❑	❑
agitation	❑	❑	❑
aggressiveness	❑	❑	❑
follows simple instruction	❑	❑	❑
takes medications readily	❑	❑	❑

ABILITY	NO LOSS	NORMAL LOSS	MODERATE LOSS	SEVERE LOSS
hearing	❑	❑	❑	❑
vision	❑	❑	❑	❑
reading skills	❑	❑	❑	❑
writing skills	❑	❑	❑	❑
speech	❑	❑	❑	❑

ALPS Adult Day Services

Release of Information

By way of my signature, I provide ALPS Adult Day Services with my authorization and consent to use and disclose protected information for the purpose of treatment and/or financial assistance.

participant name: _____ start date: _____

Social Security number: _____ date of birth: _____

caregiver signature: _____ date: _____

caregiver relationship: _____

****

I, _____, on behalf of the aforementioned participant, authorize ALPS Adult Day Services to do the following. I understand this authorization will remain in effect until I provide written instructions otherwise.

PLEASE CIRCLE YOUR CHOICE(S):

1. *ALPS **may / may not** call me at work.*
2. *ALPS **may / may not** leave a message for me at work.*
3. *ALPS **may / may not** release the participant's information to authorized physicians.*
4. *ALPS **may / may not** release the participant's information to authorized providers for possible financial assistance.*
5. *ALPS **may / may not** release the participant's information to the following person(s) or organizations*:

name: _____ phone: _____

name: _____ phone: _____

name: _____ phone: _____

caregiver signature: _____ date: _____

ALPS Adult Day Services

MEDICAL INFORMATION RELEASE FORM

To the Doctor(s) of _____:
participant's name

I hereby authorize you to release to ALPS Adult Day Services any and all medical or confidential information contained in the record of:

full name of participant: _____

date of birth: _____

address: _____

_____

****

*I further authorize **ALPS Adult Day Services** to release any and all health information contained in the ALPS health records to any doctor who is providing treatment for* _____:
participant's name

_____ _____
patient or authorized representative *date*

_____
phone

Please fax or mail information to ALPS at:

fax 423.587.9234
phone 423.587.9149
600 N. Daisy St.
Morristown, TN 37814

ALPS Adult Day Services

Grievance Policy Agreement

participant name: _____ start date: _____

The ALPS Adult Day Services program is committed to providing the highest quality of care to our participants, and their families. If, in the event any aspect of our care has been less than satisfactory, we want to know. We encourage the family or the participant to tell us if he, she, or they are dissatisfied with our care. If you have a complaint or concern, please call (423) 587-9149.

If in the event you have a complaint, inform the Family Services Coordinator or Clinical Supervisor; you may also communicate directly to the Executive Director.

A verbal response will occur within 24 hours. A written response is available upon request.

If the complaint is related to the Child and Adult Care Food Program (CACFP) program or Civil Rights, a written allegation and response will be provided to the complainant and to the Tennessee Department of Human Services.

If you are not satisfied with our responses, you may communicate directly with the ALPS Board of Directors president or chairperson of the Program Services Committee. These names will be made available to you, upon request, to assist with this process.

Since this agency is a recipient of taxpayer funding, if you observe the Executive Director or any employee engaging in any activity which you consider to be illegal, improper, or wasteful, please call the state comptroller's office toll-free hotline: 1-800-232-5454.

****

I have read, understood, and agreed to the above ALPS policy:

caregiver name (printed): _____ date: _____

caregiver signature: _____ date: _____

ALPS Adult Day Services

Grievance Policy Agreement

participant name: _____ start date: _____

The ALPS Adult Day Services program is committed to providing the highest quality of care to our participants, and their families. If, in the event any aspect of our care has been less than satisfactory, we want to know. We encourage the family or the participant to tell us if he, she, or they are dissatisfied with our care. If you have a complaint or concern, please call (423) 587-9149.

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****

I have read, understood, and agreed to the above ALPS policy:

caregiver name (printed): _____ date: _____

caregiver signature: _____ date: _____

Tennessee Department of Human Services (TDHS)		**Form HS-1949D** Revised May 2011

Child and Adult Care Food Program (CACFP)

INCOME ELIGIBILITY APPLICATION FOR ADULT CARE CENTER PARTICIPANT

PART 1 – ADULT'S NAME
(Please complete only one application form per adult) : _____

Last First MI Date of Birth

PART 2A – HOUSEHOLDS THAT ARE CURRENTLY RECEIVING BENEFITS THROUGH THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP), SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM, OR MEDICAID PROGRAM FOR ADULT CARE THROUGH THE TENNESSEE HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER (If your household is now receiving benefits under one or more of these programs, complete this part and sign the statement in Part 3 - Do not complete Part 2B.)

SNAP Case No.: _____ SSI Case No.: _____

Medicaid HCBS Waiver Attached: ____ Yes ___No (Check One)

PART 2B – ALL OTHER HOUSEHOLDS (If no information is entered in Part 2A above, complete this part and sign the statement in Part 3.) Enter below the name of the adult participant, and his or her spouse and/or any other individual(s) who reside with the participant and who depend on the participant for economic support. If you need more space, use a separate piece of paper. Use Line 1 to identify the individual enrolled in the adult day care center.

Names of All Household Members	Earnings from Work (Before Deductions)	Child Support, Alimony or Other Income	Payments Received from Pensions, Retirement, & Social Security
1.	$_____ per year	$_____ per year	$_____ per year
2.	$_____ per year	$_____ per year	$_____ per year
3.	$_____ per year	$_____ per year	$_____ per year
4.	$_____ per year	$_____ per year	$_____ per year

Total Number of Household Members: ___ Total Yearly Income for Household from All Sources: $ _____ Yearly income is calculated as follows: Multiply Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers.

PART 3 - SIGNATURE (The signature of the adult participant or other authorized individual is required.)

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct and that the SNAP and/or SSI case numbers are correct or that all income is reported. I understand that this information is being given for the receipt of Federal Funds; that institution officials may verify the information on the statement and the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult :	Signature of Adult:	Social Security Number (only last four digits):

Street:	City:	State and Zip Code:	Home Telephone:

PART 4 – ETHNIC/RACIAL IDENTITY (**You are not required to answer this question**.): **For Ethnicity**, please check one of the following: ___ Hispanic or Latino ___ Not Hispanic or Latino. **For Race**, please check one or more of the following: ___ American Indian or Alaskan Native ___ Asian ___ Black or African American ___ Native Hawaiian or Other Pacific Islander ___ White. Please see the definitions of Ethnicity and Race on the back of this application.

FOR INSTITUTION OR SPONSOR STAFF USE ONLY: Eligibility Classification (Circle) Free Reduced-Price **or** Paid
Basis for Classification (Circle) Categorically Eligible **or** Income Eligible

Determining Official Signature: _____ Date: _____

INCOME ELIGIBILITY APPLICATION INSTRUCTIONS

PART 1A - PARTICIPANT INFORMATION: All HOUSEHOLDS COMPLETE THIS PART.

(1) Print the name of the adult enrolled at the adult care facility.

PART 2A - HOUSEHOLDS RECEIVING SNAP, SSI ASSISTANCE OR MEDICAID PROGRAM BENEFITS THROUGH THE TENNESSEE HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER COMPLETE THIS PART AND PART 3.

(1) List your current SNAP or SSI case number for your household, or attach a copy of HCBS Waiver. Do not complete Part 2B.

(2) The adult participant or other authorized household member must sign the statement in Part 3.

PART 2B - ALL OTHER HOUSEHOLDS: COMPLETE THIS PART AND PART 3.

(1) Write the names of everyone in your household.

(2) Write the amount of the most recent income received on a yearly basis for each household member. The income may be for the current month, the amount projected for the first month the application is made for, or for the month prior to application. This income is the amount before taxes or any deductions are made. Also, indicate the source of the income. Refer to examples below for income to report.

INCOME TO REPORT

Earnings from Work	Retirement/Social Security	Other Income Sources	Child Support/Alimony
Wages/salaries/tips	Pensions	Disability benefits	Alimony/child support benefits/payments
Strike benefits	Supplemental Security Income	Cash withdrawn from savings	
Unemployment benefits	Retirement income	Interest/dividends	
Worker's Compensation	Veteran's payments	Income from estates/trusts/investments	
Net income from self-employment	Social Security Income	Regular contributions from persons not living in the household	
		Net royalties/annuities/net rental income	

PART 3 - SIGNATURE AND SOCIAL SECURITY NUMBER: All households complete this part.

(1) The adult participant or other authorized household member must sign the certification statement. If a functionally impaired or elderly adult is not able to complete an application for himself or herself, an adult family member or guardian may complete the application. However, if the participant is unable to complete the application and if no adult family member or guardian is available, the center's staff may complete the application on the participant's behalf only if the participant is categorically eligible for free meals. The participant's file must contain documentation of his or her categorically eligibility. If the signature is provided by an individual other than the adult for whom the application is being made, a written statement that outlines the circumstances must be attached to the application.

(2) The adult household member who signs the statement must include the last four digits of his/her Social Security Number. If he/she does not have a Social Security Number, write "none". If you listed a SNAP or SSI case number or provided documentation of Medicaid Program benefits through the Tennessee Home and Community Based Services (HCBS) Waiver, the last four digits of the Social Security Number is not needed.

(3) The income eligibility application is valid for one calendar year from the date of the signature of the Determining Official. You will be contacted by the staff of the CACFP Sponsoring Agency to update the information contained in this application before the close of the eligibility period. The staff of the CACFP Sponsoring Agency is required to verify and certify the eligibility of your household every 12 months. Section 9 of the National School Lunch Act requires that, unless Part 2A is completed, you must include the last four digits of the Social Security Number of the household member signing the statement or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last four digits of the Social Security Number is not mandatory, but if this Social Security information is not provided or an indication is not made that the adult household member signing the statement does not have a Social Security Number, the statement cannot be approved. The last four digits of the Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP, SSI or HCBS Waiver Office to determine current certification for receipt of benefits under these programs, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

PART 4 - RACIAL/ETHNIC IDENTITY: You are **not required** to answer this question to receive meal benefits. However, this information will help ensure that everyone is treated fairly.

Definition of Ethnicity: *Hispanic or Latino* means *a* person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Definition of Race: *American Indian or Alaskan Native* means a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. *Asian* means a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. *Black or African American means a* person having origins in any of the black racial groups of Africa. *Native Hawaiian or Other Pacific Islander means a* person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. W*hite* means a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the CACFP on the grounds of race, color, sex, age, disability, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

CHILD AND ADULT CARE FOOD PROGRAM
SAMPLE HOUSEHOLD LETTER FOR
NONPRICING ADULT CARE CENTER

Dear Household Member:

This adult care facility participates in the Child and Adult Care Food Program (CACFP) which is administered by the Tennessee Department of Human Services and funded by the U.S. Department of Agriculture. The CACFP provides reimbursements to our facility for the costs of serving nutritious meals to all enrolled adults. This allows our facility to better serve the adult member of your household who is enrolled at our facility.

As provided by the program's regulations, the amount of reimbursement that we may receive for our meal services is dependent upon the income eligibility of the enrolled adults. The eligibility categories for enrolled adults are free, reduced-price and paid. The highest meal reimbursement is provided for adults who are eligible for the free meal category. The lowest meal reimbursement is provided for adults who are placed in the paid meal category. The eligibility of each enrolled adult must be updated at least once each year.

To determine the amount of meal reimbursements for our facility, we need your assistance. You will find attached a copy of an income eligibility application and income guidelines for the reduced-price meal category. Please use the instructions on the back of the application to complete and return it to our facility. All income eligibility applications that are received for enrolled adults are placed in secured files at our facility and treated as confidential information. The information given on the application may be verified by authorized state and federal officials.

If the enrolled adult now receives benefits under the Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI) Program, or Tennessee Home and Community Based Services (HCBS) Waiver for Adult Care through the Medicaid Program, you do not have to enter any income data on the application. If these benefits are received, please only provide the case number for the SNAP or SSI assistance, copy of the HCBS waiver and the name of the enrolled adult. If more than one adult from your household is enrolled at our facility, please complete a separate application for each adult. Also, please have the enrolled adult or other authorized person sign the application. Please note that if the benefits under the SNAP, SSI Program or HCBS Waiver for Adult Care are terminated for the enrolled adult, our facility must be notified by the enrolled adult or authorized household member.

If benefits under the SNAP, SSI Program, or HCBS Waiver for Adult Care are not received, please provide income information for all household members who reside with the adult participant and who depend on the adult participant for economic support. Do not enter any information on the application for those household members who do **not** depend upon the adult participant for economic support. If the household income is equal to or less than the attached income guidelines, the enrolled adult is eligible for the free or reduced-price category. The loss of income through the unemployment of any members of your household or family may qualify

the enrolled adult for the free or reduced-price meal category during the period of unemployment.

To enter yearly income amounts, you will need to convert your income as follows: Multiple Weekly income by 52, Bi-weekly income (received every two weeks) by 26, Semi-monthly income (received twice a month) by 24, and Monthly income by 12. Do not round up any numbers during the conversion.

Please be sure that the enrolled adult or other authorized person signs the application, and returns it by _____ to _____.

The meal services provided by this facility are available to all enrolled adults regardless of race, color, national origin, sex, disability, or age. If you believe that you or an enrolled adult from your household have been discriminated against, please immediately write to one or both of the following addresses:

U.S. Department of Agriculture
Director of Office of Civil Rights
Whitten Building, Room 326-W
1400 Independence Avenue, SW
Washington, DC 20250-9410
Telephone: (202) 720-5964 (Voice and TDD)

Tennessee Department of Human Services
Child and Adult Care Services
400 Deaderick Street
Nashville, Tennessee 37243-1403
Telephone (615) 313-4749

You may also file a complaint with our facility. Complaint forms and procedures are available from our facility upon request.

Sincerely,

_____
Name of Title of Facility Representative

_____
Date

Attachments: Income Eligibility Application
Income Eligibility Guidelines for Reduced-Price Meals

ALPS Adult Day Services

Application for Sliding Scale Fee

participant name: _____ start date: _____

caregiver: _____ relationship: _____

billing address: _____

city/state/zip: _____ phone: _____

This form is optional. For families who ***do not*** wish to complete the information below a fee of $60.00 per day will be charged. Families accessing third-party payers (i.e. insurance companies, Workers' Compensation, and/or any state/federal programs) ***do not*** have to complete the information below.

If you wish to apply for sliding scale fees, complete the following for the participant AND his/her spouse (if applicable). Please include the documentation of the participant's most recent income tax form. ***This application cannot be processed without documentation of income. The full rate of $60.00 per day will be charged until documentation is provided***.

MONTHLY INCOME:

	participant	**spouse (if applicable)**	**total**
Social Security	$ _____	$ _____	$ _____
retirement/pension	$ _____	$ _____	$ _____
other income	$ _____	$ _____	$ _____
totals	**$ _____**	**$ _____**	**$ _____**

TOTAL MONTHLY INCOME $ _____

I certify the information presented is true and accurate to the best of my knowledge.

Caregiver signature: _____ date: _____

*** A registration fee of $60.00 is required of all new participants. This fee covers the expense of processing this application and the additional paperwork required by our program and state licensing procedures.**

(For ALPS use only)

daily fee: _____

all documentation provided: _____

V.A.: _____

Medicaid Waiver: _____

USDA status: _____

registration fee paid: _____

scholarship approval: _____ AA or _____ FT

group 1: _____

group 2: _____

interviewed by: _____

In addition to all of the required paperwork, we ask that you also bring for your loved one:

1. A complete change of clothing (pants, shirt, underwear, socks, etc.) that can be left here for emergencies.

2. Any type of protective garment your loved one may use.

3. Social Security, Medicare, V.A., and/or insurance cards (any that you would present upon hospital admission) of which we will make a copy and keep on file.

4. Any legal document that you would present upon hospital admission – Power of Attorney, Healthcare Power of Attorney, Living Will, specific "Do Not Resuscitate" order. We will make copies of these as well.

5. If we are to give any prescription or nonprescription medications during the day, we require that the medicines be in their original containers. Pharmacies are very willing to give a second bottle with the prescription on it if you only ask.

Thank you!