**ACKNOWLEDGEMENT AND CONSENT FOR SERVICES**
**TURNAGAIN SOCIAL CLUB, LLC**

I acknowledge that received a copy of TSC's handbook that includes the following policies:

- ☐ Dates and hours of service and holidays
- ☐ Eligibility and admissions
- ☐ Philosophy / mission statement
- ☐ Financial Policy
- ☐ Facilities
- ☐ Transportation
- ☐ Recipient's rights
- ☐ Mandatory reporting requirements
- ☐ Services and activities
- ☐ Meals, snacks, and hydration
- ☐ Medication
- ☐ Illness
- ☐ Scheduling outside services
- ☐ Concerns and complaints
- ☐ Termination of services and right to appeal
- ☐ Nondiscrimination
- ☐ Photographic and Voice Consent
- ☐ Smoking
- ☐ Confidentiality and HIPAA
- ☐ Personal property
- ☐ Emergency procedures
- ☐

I have read and fully understand the above information. I agree to follow the policies of TSC and understand that I am financially responsible for all services rendered. I will be liable for all financial and legal collection fees if applicable.

I acknowledge and understand that TSC relies on information that I or my representative, as applicable, provides to develop an individualized adult day care service plan. I further acknowledge and understand that it is my responsibility or my representative's, as applicable, to update TSC regarding changes in my health, cognitive status, abilities, and needs. I understand and acknowledge that there are certain risks inherent to adult day care services including participation in activities and transportation.

I acknowledge that TSC's staffing ratio, services and facilities are not guaranteed to prevent an elopement.

**Notice of Privacy Practices.**

- ☐ I received TSC's Notice of Privacy Practices describing how my medical information may be used and disclosed, how I can obtain access to this information, and my rights and how to exercise my rights. I understand my right to receive and refuse services, to privacy and confidentiality, to respectful treatment and to be informed about all aspects of services provided to me.

_____ _____
Recipient or Representative Signature Date

**By signing below, I acknowledge that I have received a copy, read and understood TSC's handbook that includes the above policies and information about the staffing, activities, and services provided by TSC. I have had the opportunity to ask questions about the services and my rights and I consent to follow and be bound by TSC's policies and the terms and conditions of TSC's Service Agreement.**

_____ _____
Recipient Signature Recipient's Representative Signature

_____ _____
Name Name / Relationship

_____ _____
Date Date

# State of Alaska

**Department of Health and Social Services**
**Division of Senior and Disabilities Services**

## AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Medicaid # _____ Record # or Other ID: _____ Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

**Person/Organization Releasing Information:** Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf and _____
(name of ICAP Respondent or Care Coordinator may be inserted. ***Note** if text box is not used insert "N/A"; if text box is used, do not use this form to request any records or information except from the person or agency named in the text box)

**Person/Organization Receiving Information:** (*include address if needed*) Alaska Department of Health and Social Services, Senior & Disabilities Services and Turnagain Social Club (name of Care Coordinator or PCS Agency representative or ADRC or DDRC representative may be inserted)

**Description of Information To Be Released:** *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description)* **health care provider notes (excluding psychotherapy notes, as defined by HIPAA), history & physical records, admission notes, discharge summaries, discharge plans, notes from clinic visits, laboratory records and reports, imaging and radiology records and reports, swallow studies, inpatient and outpatient records, physical therapy records, occupational therapy records, respiratory therapy records, dialysis records, chemotherapy records and the personal knowledge of respondents or agencies named in my ICAP application if applicable. Note* release records that are current within the previous 12 months from the date of the request.** *The purpose of the release of this information is: to obtain health care records and financial information needed to determine eligibility to receive or continue to receive services and other benefits through programs managed by the State*

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: _____

_____ _____
Signature of Client or Legal Representative (Or Witness if signature is by mark) Date

_____ _____
Printed Name of Legal Representative or Witness Description of Legal Representative's Authority

*NOTE: This authorization was revoked on: _____(Date)(see attached revocation)*

**Member:**_____ **Date:**_____

# Determine Your Nutritional Health Checklist

Read the statements below. Circle the number in the "yes" column for those that apply to you or someone you know. For each "yes" answer, score the number in box. Total your nutritional score.

| | YES |
|---|---|
| I have an illness or condition that made me change the kind and/or amount of food I eat. | 2 |
| I eat fewer than 2 meals per day. | 3 |
| I eat few fruits or vegetables or milk products. | 2 |
| I have 3 or more drinks of beer, liquor or wine almost every day. | 2 |
| I have tooth or mouth problems that make it hard for me to eat. | 2 |
| I don't always have enough money to buy the food I need. | 4 |
| I eat alone most of the time. | 1 |
| Without wanting to, I have lost or gained 10 pounds in the last 6 months | 2 |
| I am not always physically able to shop, cook and/or feed myself. | 2 |
| Total your nutrition score | |

**Score It!**

| | |
|---|---|
| 0 - 2 | Good, recheck in 6 months! |
| 3 - 5 | Moderate nutritional risk. Improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck in 3 months. |
| 6 or more | You are at high nutritional risk. Bring this checklist next time you see your doctor, dietician or other qualified health or social service professional. Ask for help to improve your nutritional health. |

*The Nutrition Screening Initiative • 1010 Wisconsin Avenue, NW • Suite 800 • Washington, DC 20007*
*The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.*

**Follow-Up Date:** _____

**Employee Initials:** _____