



FORMS

(to be returned to Shepherd's Place)

Fairhope United Methodist Church
Wesley Hall
155 South Section Street
Fairhope, AL 36532

251-928-1148

shepherdsplace@fairhopeumc.org
www.shepherdsplacerespite.com

Revised 9/15



Shepherd's Place

Welcome to Shepherd's Place!

We are a part of Caring Ministries at Fairhope United Methodist Church and are excited that you or your loved one are considering enrollment in our program.

Shepherd's Place is a ministry of nurture and care. This ministry will provide relief for the caregiver and bridge the gap between independent living and highly restrictive care. Our activities are designed to promote cognitive, language, social and motor skills. We will serve a hot lunch daily in addition to a morning snack.

Please review the enclosed information as well as the Shepherd's Place Admission Agreement. Complete and return the appropriate forms including the physician's statement by the specified time.

Thank you for your time and welcome!

A handwritten signature in black ink that reads "Leisa Richardson RN". The signature is written in a cursive style.

Leisa Richardson, RN
Director of Shepherd's Place

A handwritten signature in black ink that reads "Ann Pearson". The signature is written in a cursive style.

Ann Pearson, PhD
Director of Caring Ministries

Shepherd's Place has a twofold mission: to nurture and care for individuals with memory and physical challenges associated with, but not limited to, Alzheimer's, Dementia, Parkinson's, Stroke & Traumatic Brain Injury; and to provide respite for the caregiver, thereby reducing the physical, mental and emotional impact of caregiving.

Shepherd's Place

Conditions and Admission Agreement

Initial each item:

_____ 1. **Admission:** Acceptance into Shepherd's Place will be based on an assessment of the prospective participant by the staff of Shepherd's Place. The applicant, caregiver and any family members will meet to provide information regarding ambulatory status, ability to care for personal needs and the ability to function in a social/group setting. The staff will determine the ability of Shepherd's Place to meet the participant's needs and if the participant meets minimal requirements for Shepherd's Place. Acceptance into the program is also dependent on a physician's statement. Caregiver/participant history form should be completed and returned before or on the first day of attendance. The physician's release statement must be completed and returned within seven days of the first day of attendance.

_____ 2. **Schedule:** Monday through Thursday ; 9:00 a.m. - 1:00 p.m. ; \$40.00 per day

Our doors will be open 5 minutes before the hour for participant drop-off and will close 5 minutes after the hour for participant pick-up.

Unless arrangements have been made in advance, participants arrival should be no earlier than 5 minutes before the opening & pick-up no later than 15 minutes after closing hour. A charge of \$20.00 will be assessed per incident.

Changes to the schedule may be made at the discretion of the staff and will be communicated with the caregiver.

_____ 3. **Program Billing/Charges:** Statements will be prepared at the end of the month based on the participant's attendance. Full payment is due upon receipt/by the 10th of the month. A late fee of \$25.00 will be assessed. A one time non-refundable fee of \$150.00 is due at the time of registration.

_____ 4. **Absentee Policy:** Caregivers should call 251-928-1148 to notify of absences. Participant should not attend with any current or potential health issues.

_____ 5. **Record Keeping:** The caregiver should inform the staff of any changes in the participant's medical conditions, emergency contact numbers or any other circumstances that may be necessary for the proper care of the participant.

_____ 6. **Medical Emergency/Incident Procedures:** The caregiver/family will be notified as soon as possible of any incident involving the participant. In the event of a medical emergency, **911 will be called first and then the family.**

Shepherd's Place

Conditions and Admission Agreement

_____ 7. **Medications:** Shepherd's Place discourages administration of medication. If medications are required during Shepherd's Place hours, they must be appropriately labeled and all required forms completed. Medications must be labeled and in a daily medication planner. Caregiver should notify Shepherd's Place staff of any medication changes.

_____ 8. **Suspension/Discharge from Shepherd's Place:** The caregiver will be notified of any socially inappropriate behavioral by the participant. In the event of a physical or verbal altercation, caregivers will be notified and required to pickup the participant immediately. Participant will be suspended for 1 week, followed by a conference with staff before a decision is made regarding returning to Shepherd's Place. Shepherd's Place reserves the right to discharge any participant when, based on an evaluation by the staff, the participant is no longer appropriate for the program. Every effort will be made to accommodate the participant's needs and appropriate referrals for continued care will be provided.

I have read and agree to the above conditions and requirements.

Signed (Caregiver) _____ **Date** _____

**SHEPHERD'S PLACE
PARTICIPANT INFORMATION**

To be completed by participant or caregiver:

Date: _____

Full Name: _____ Name called: _____

Address: _____

Phone: _____ Cell: _____

Email Address: _____

Gender: _____ DOB: _____ Place of Birth: _____

Places lived during lifetime: _____

Profession, trade or occupation before retirement: _____

Years of Education: _____

Hobbies/Interests: _____

Names of Children: _____

Special Friends: _____

Pets Names: _____

Present living arrangements: _____

Church/ Religion: _____

Marital Status: _____ Spouse's Name: _____

If spouse deceased, year of death: _____

Name of primary caregiver: _____ Relationship: _____

Address: _____

Phone: _____

Description of current activities:

Health Issues:

Is applicant diabetic? _____ Insulin dependent? _____ Anticoagulant therapy? _____

Does applicant smoke? _____

Primary Care Physician: _____ Phone: _____

Date last seen by physician: _____

Date of last: Vision Exam _____ Hearing Exam _____ Dental exam _____

Does the applicant wear (please check): _____ Glasses _____ Hearing Aid _____ Dentures/Partial

Meal Restrictions/Limitations: _____

Allergies: _____

Hospital of choice: _____

In the event of an emergency, please list persons and contact numbers in order of desired notification:

1. Name: _____ Phone: _____ Relationship: _____

2. Name: _____ Phone: _____ Relationship: _____

Additional comments:

Please list all medications:

Name of Medication	Dosage	Frequency

Signature of Participant or Caregiver

Date

Physician's Release Statement

Dear Doctor:

Your patient (or their caregiver) _____ D.O.B. _____
has requested to attend Shepherd's Place. Shepherd's Place is a ministry of nurture
and care for individuals with memory and physical challenges associated with, but not
limited to, Alzheimer's, Dementia, Parkinson's, Stroke and Traumatic Brain Injury.
Shepherd's Place is a four day a week program at Fairhope United Methodist Church
that fosters cognitive and social stimulation for the participant and provides relief for
the caregiver. Based upon your evaluation, does your patient qualify for the program?

Yes _____

No _____

Signed _____ Date _____

Date of last TB screening or chest x-ray _____

Additional comments:

Please feel free to call with further questions.

Leisa Richardson, RN
Director of Shepherd's Place
shepherdsplace@fairhopeumc.org

251-928-1148
251-928-7328 (fax)

Ann Pearson, PhD
Director of Caring Ministries
ann.pearson@fairhopeumc.org

**SHEPHERD'S PLACE
CONSENT FORM A (ACTIVITIES RELEASE FORM)**

All participants have the right to personal privacy and confidentiality.

I, _____, agree to permit Shepherd's Place to:

(Please Initial)

_____ Use or take videos of the participant for activities or publicity.

_____ Take photographs or display photographs for activity or publicity.

_____ Put participants first name on Birthday Board.

_____ Use participants first name in Shepherd's Place or FUMC Newsletter.

_____ Identify participant's crafts and art work with participant's first name.

Date

Participant or Caregiver

Indemnification and Hold Harmless Agreement and Release

I, the undersigned, and caregiver and/or guardian of _____ (the "Participant") hereby acknowledge the inherent risks and challenges associated with the care of the Participant while in the care of the Shepherd's Place program administered and operated by the Fairhope United Methodist Church and the Shepherd's Place Foundation (the "Program"). Recognizing such risks and challenges, I hereby indemnify and agree to hold harmless and release Fairhope United Methodist Church and Shepherd's Place Foundation, and their employees, members, directors, committee members, advisory board members, volunteers, and successors and assigns, free, clear and harmless from any and all liability, damages, claims and suits associated with the care of the Participant while involved and participating in the activities of the Program. I hereby assume responsibility for all medical costs that the Participant may incur while in the Program. Participant and/or the undersigned shall be responsible for any and all damages to property or persons while participating in the Program. In addition, as a condition to the Participant being allowed to participate in the Program, I shall have the physician's release statement completed and returned within seven (7) days of the Participant's first attendance in the Program.

Caregiver/Guardian

Date