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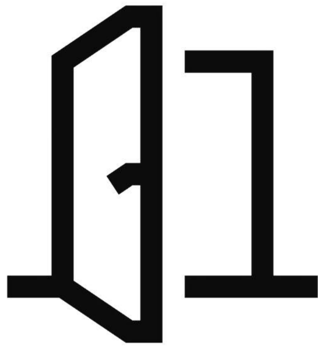

Open Doors

Adult Day Program

<u>REGISTRATION PACKAGE</u>

Thank you for your interest in Open Doors Day Program. In this package you will find:

1. Fees and payment PLEASE KEEP FOR YOUR RECORDS
2. Registration form
3. Medical forms
4. Sample Program

Please don't forget to:

- Fill in with as much details as possible
- Read Our Policies and Procedures
- Return completed package as soon as possible
- Call Kendra Pilon at 519-900-6817 if you have any questions or concerns

FEES AND PAYMENT

Please read through the following carefully.

PAYMENTS:

Fees are due monthly, on the 15th, for the following month. Schedules and calendars for each following month will be sent out on the first business day of the preceding month. Payments can be made by e-transfers or cheques. I understand a $40 fee will be charged for each cheque returned for NSF or other reasons.

***All fees are non transferable or refundable due to staffing needs.**

FULL DAY FEES

Support fees will be determined after a support assessment has been made. We have a few different levels of support. 1:1, 1:6.

HALF DAY FEES

Support fees will be determined after a support assessment has been made. *Friends coming to the centre with their own support worker will be given a discounted rate.

HOURLY FEE

Hourly support fees for after school drop in or centre drop in will be $25.75/hr

ALL RATES TO BE DISCUSSED AT ASSESSMENT

TERMINATION NOTICE

Written notice to the director must be given a minimum of two weeks prior to the withdrawal of the participant.

I have read the above and agree to the terms stated.

SIGNATURE ____ DATE ____________

Hello Open Door Family!

For booking days you will be sent the following month's schedule and calendar at the beginning of the preceding month. For example, we are asking you to choose your days for the month of June and return such requests to us by **May 15th** with your payment. This will help us with our planning and scheduling of our staff as we continue to grow.

Our Sick Day policy is as follows. When your family member misses a day at the center that is already paid for, we will now be offering the opportunity for you to reschedule that day. This will be done by submitting a request for the rescheduled date to be approved based on the availability of staff and scheduling. **No rescheduled requests are guaranteed.** The number of days you will be allowed to request will be based on the number of days per week you have committed to. For example, if a participant attends 5 days a week, you will be allowed to request up to 10 rescheduled days per calendar year. If they attend 4 days a week you will be allowed up to 8 rescheduled days per calendar year. If they attend 3 days per week, you will be allowed to request up to 6 rescheduled days per calendar year. The full policy will be available in our policy folder, soon to be available for your reference.

Open Doors is a PEANUT,PINEAPPLE AND FISH/SEAFOOD FREE CENTRE DUE TO ALLERGIES. Please do not bring anything with either of these for lunches,

If you have any questions about these adjustments, please do not hesitate to contact me. Thank you for helping to make Open Doors a great place for all of our Friends!

Thanks
Kendra Pilon
Director
Open Doors Adult Day Program

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OPEN DOORS REGISTRATION FORM

PARTICIPANT'S NAME ____

DATE OF BIRTH ____

ADDRESS ____

PHONE ____________________________ CELL PHONE________________________

HOW MANY DAYS AT THE CENTRE PER WEEK ___________________________________

ARRIVAL TIME _____________________ DEPARTURE TIME______________________
*THE PROGRAM IS OPEN MONDAY - FRIDAY FROM 9AM TO 4PM

EMAIL ADDRESS____________________________________(will be used for all communication)

EMERGENCY CONTACT INFORMATION

1) GUARDIAN'S NAME ____

EMAIL ADDRESS(used for all correspondence)

____

PHONE ___________________________ Ext.______________

PLACE OF EMPLOYMENT ____

ADDRESS ____

2) CONTACT'S NAME ____

PHONE __________________________ Ext.______________

ADDRESS ____

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DOCTOR'S NAME ____

ADDRESS ____

PHONE NUMBER ____

Please note: It is the guardian's responsibility to let the supervisor/staff know of any changes to the information included on this form.

MEALS AND SNACKS

All meals and snacks are to be provided by the participant. A list of items not allowed (due to allergies) at the centre will be issued once registration is complete.

ILLNESS

A participant will stay home for a minimum of 24 hours when any of these symptoms that are unusual to them are present:

-Cough	-Runny nose	-Sore throat
-Diarrhea	-Nausea or vomiting	-Headache
-Extreme Fatigue	-Fever of greater than 100.4 F	

ABSENTEE POLICY

I will receive no reduction in fees for days that the participant may be absent (due to illness, appointments, etc.).

PERMISSION TO PHOTOGRAPH (circle your preferences)

I give / do not give Open Doors Day Program staff permission to photograph the participant during the program. Pictures may / may not be used for social media platforms and advertising. Photos may / may not be used in the center.

I have read the above and agree to the terms stated.

GUARDIAN SIGNATURE ____________________________________ DATE ____________

MEDICAL RELEASE

In the event of a serious occurrence the participant will be taken to the hospital, without consent and will only be treated if life threatening.

It is very important that staff know how to contact you at all times.

I hereby consent to have the participant examined and treated by a physician if an emergency should arise.

PARTICIPANT'S NAME ____

ADDRESS ____

PHONE ________________________________

BIRTH DATE (D/M/YR) ____

HEALTH CARD #____________________________________ (Include the letters at the end)

SIGNATURE _______________________________________ DATE _______________

*The centre will only administer prescribed medication from a physician. Medication must have the participant's name on it.

*No over the counter medications will be given without a Doctor's prescription on file.

*All medications must be in original packaging from Pharmacy.

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Open Doors

MEDICAL FORM FOR PHYSICIAN

PARTICIPANT NAME ____

PHYSICIAN NAME _________________________ PHONE ____________________

PHARMACY_______________________________ PHONE ____________________

DIAGNOSIS ____

____

____

ALLERGIES ____

____

____

LAST MEDICAL EXAMINATION COMPLETED ON (D/M/Y)________________________

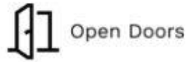
TREATMENT PLAN ____

____

____

LIST MEDICATION NAME, EXACT DOSE, FREQUENCY, TIME, ROUTE, AND REASON

____



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____

____

PHYSICIAN SIGNATURE ________________________________ DATE ___________

STANDING ORDERS 1

PARTICIPANT NAME ____

BIRTH DATE (D/M/YR)____

PHYSICIAN NAME ____

PHONE ____

PHARMACY____

PHONE ___________________________

ANY WRITTEN INSTRUCTION FOR PARTICIPANT CARE _________________________

____

____

FOR EXAMPLE: CHEST PHYSIO OR RANGE OF MOTION_________________________

____

____

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PHYSICIAN SIGNATURE ___________________________________ DATE___________

STANDING ORDERS 2

PARTICIPANT NAME ____

BIRTH DATE (D/M/YR)____

Personal Assistance Service Device(s) this participant will use while at Open Doors
(please check all that apply):

□ **Wheelchair:** This individual uses a wheelchair with a lap belt or restraining belt to assist the individual with a physical disability with positioning or balance.
Additional instructions are as follows:(Insert information on tilt of the chair for certain activities of daily living, uses of a stability belt if applicable).

____

□ **Mechanical Lift:** This individual weighs more than 70 pounds and requires the use of a mechanical lift. This will allow the individual to be transferred between a bed and a chair or other similar resting places.

□ **Commode:**This individual requires a commode to assist with stabilization/ safety during elimination. While an individual is using a commode he/she will be monitored at all times. Additional instructions are as follows: (Insert information on the use of the lap belt or safety bar).

____

□ **Other Equipment:** (e.g. list any other equipment that restricts movement and that the

participant may be unable to release themselves from).
Please specify the device and how it will be used for a routine activity of daily living.

Additional Instructions ____

____

____

HEALTH PRACTITIONER SIGNATURE ______________________ DATE __________

GUARDIAN SIGNATURE ______________________________ DATE __________

LIFE THROUGH MY EYES

To help us provide the best care possible please complete this form as much as you feel comfortable sharing.

NAME ____

I PREFER TO BE CALLED ____

PLACES I HAVE LIVED ____

IMPORTANT RELATIONSHIPS (friends, family, pets) _____________________________

____

____

HOBBIES ____

THINGS I LIKE TO WORK ON ____

____

TO ENJOY MY DAY I NEED TO HAVE (eg. glasses, lotions, pillow, book) ________________

____

____

IF I BECOME FRIGHTENED OR UPSET, THESE THINGS HELP ME __________________

____

____

SOME OF MY FAVORITE THINGS
-MOVIES/TV SHOWS ____

-BOOKS/ MAGAZINES ____

-MUSIC____

-FOOD/DRINKS ____

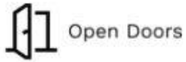
-ACTIVITIES____

-OTHER ____

IF YOU WERE TO ASK ME ABOUT MY LIFE THIS IS WHAT I WOULD SAY_____________

____

____



MY DAILY LIFE COMMUNICATION (language spoken, meanings of special words, supports used, any special instructions) ____

____

____

NUTRITION (tools needed, assistance level required, please list and instructions) _________

____

____

ELIMINATION (toileting needs, items needed) _________________________________

____

____

MOBILITY/POSITIONING ____

____

____

____

____

BEHAVIORAL CONSIDERATIONS (BSP?) ___________________________________

____

____

____

____

STRENGTHS ____

____

____

____

____

ANY ADDITIONAL INFORMATION ____

____

____

____

Additional Notes