ST·ANN ADULT DAY SERVICES
CATHOLIC CHARITIES IN ACTION

3308 Benson Avenue
Baltimore, MD 21227
(667) 600-2680
fax (667) 600-4095
TDD 1 (800) 735-2258

A Medical Adult Day Care Program

Location:	South Baltimore, next to St. Agnes Hospital On the campus of the Jenkins Community	
Affiliation:	Senior Services, A Division of Catholic Charities	
Hours:	Monday – Friday	7:00 a.m.– 5:00 p.m.
	Saturday	CLOSED
	Sunday	CLOSED

Services available:

1. **DOOR TO DOOR transportation** in a wheelchair accessible van**.***
2. Gerontological **nurse** monitoring and offering preventive care.
3. Meaningful **activities** one-on-one and in small groups.
4. Personalized **meals** including lunch and two snacks.
5. Assistance with **personal care** and activities of daily living.
6. Licensed **social worker** supporting participants and caregivers.
7. **Consultations** with occupational, speech and physical therapists, opthamologists, podiatrists, and psychiatry.

Who do we serve?

We have the privilege of serving older adults who would benefits from medical supervision in a safe, secure, stimulating day program. These seniors seek to maintain their highest health and functioning level. They enjoy personal care that honors their dignity and self-worth.

These services are offered without regard to race, color, sex, national, origin, religion, age, or disability.

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Fee Structure
Fiscal Year 2025

Private Pay

$117.00 per day, with or without transportation.

For those paying privately, we request a security deposit equal to one month of service. This security deposit will be applied to the participant's final bill.

Community Medical Assistance or Medicaid Waiver

The **Medical Assistance (MA)** program is the largest payor of adult day services. In order to qualify for Medical Assistance or Medicaid Waiver reimbursement, the individual must medically and financially qualify for a medical adult day care program. Our social worker can inform you of the application process if you think you may qualify.

Senior Care Subsidy

Gap-filling funds may be available to pay for adult day services to eligible adults aged 65 or older through the Senior Care Program (for Baltimore City residents only). **You may contact Baltimore City Health Department, Office of Aging (410) 396-2273 to apply.**

Baltimore County Office on Aging Subsidy

Gap-filling funds may be available to pay for adult day services to eligible adults aged 65 or older through Baltimore County Department of Aging (for Baltimore County residents only). **You may call to (410) 887-5793 to apply.**

Veterans Administration Subsidy
Veterans who qualify for the VA subsidy receive two days of adult day care services per week. There is a copay based on income. The Medical Administration Service sends the veteran a form to fill out that will request new income information. There are some veterans that are exempt from the copay because of previous income statements or are considered service connected.

Bathing Services

St. Ann's is pleased to be able to provide bathing services to our participants. For participants who are private pay, there is a $10.00 fee when there is a one-person assist and $15.00 fee for a two-person assist (at the discretion of the Center).

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ADMISSSION AGREEMENT AND SERVICE CONTRACT

Participant _____ Social Security #_____
Medicaid # _____ Medicare #_____
Funding Source_____
Responsible Party/Agent_____

Definitions:

Responsible Party/Agent of Participant: **Person who manages, uses or controls funds or assets that legally may be used to pay the participant's share of costs or other charges for the facilities services.**

Participant: Individual who attends the program.

Caregiver: Individual(s) with whom the participant resides and who provides primary caretaking responsibility.

I. GOALS AND SERVICES

For participants enrolled in St. Ann Adult Day Services, we set the following goals:

1) to improve and/or maintain each participant's health and well-being
2) to provide holistic (medical, physical, spiritual) individual care
3) to create meaningful activities for the growth and development of the participants
4) to prevent premature or inappropriate institutionalization of participants

We also intend to:

5) establish consistent respite for caregivers
6) extend the support system for participants and caregivers
7) advocate for individuals in the midst of transition and change
8) innovate through services designed to meet the needs of participants

When accepted into the program, participants are entitled to:

A written comprehensive assessment within thirty days of enrollment that evaluates the participant's strengths and needs, and that is updated every six months or when any significant change occurs in the participant.

A written plan of care updated as needed and reviewed at least every ninety days
Nutritional services (lunch and two snacks)
Transportation to and from the center as negotiated by the participant and St. Ann
Meaningful activities of their choice
Exercise and rest
Day-to-day counseling
Referrals to community resources when appropriate
Services of a Registered Nurse when needed
Emergency Services
Monitoring of health and functional status
Consultations with health professionals as needed
Discharge planning

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II. PRIVATE PAYMENT AND NOTIFICATION

In return for services, the participant and the participant's Responsible Party/Agent agree to pay the fees set out in the attached fee schedule from the income/assets of the participant. For private payers, a one-month security deposit shall be obtained prior to service

Payment is due upon receipt of the monthly invoice. Continued participation is contingent upon full payment of the bill. Any account over two months past due and/or have an outstanding balance over $2,000.00 will lead to discharge from the program.

In the event the bill is not paid, the account will be referred to an attorney or collection agency. If it is necessary for St. Ann to secure the services of a collection agency or attorney to collect any of these charges, the Responsible Party/Agent agrees to pay all costs of collections and attorney fees. If St. Ann provides transportation and is not notified by 7:00 a.m. that a participant will not be coming in on a scheduled day, there will be a $15.00 charge added to the monthly invoice.

III. ADMISSION PROCESS

We offer admission and services without regard to race, color, gender, national origin, religion, or disability.

Prior to admission, St. Ann must have a written statement from a Physician that includes an assessment of the participant's general medical condition based on a medical evaluation performed within three months prior to enrollment and a **negative result of a Mantoux test or chest x-ray within the last 6 months.**

We do not deny admission to an individual solely because the individual has a communicable disease. Prior to admitting an individual with a communicable disease, St. Ann is required to notify the Maryland Department of Health and Mental Hygiene. The Department may prohibit us from accepting an individual with a communicable disease if it is determined that individual could pose a risk to the health, safety or welfare of others.

Participant:_____

Responsible Party/Agent: _____

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We are not able to serve people who are:

Bedfast or who do not have sufficient stamina to benefit from a group setting, in an infectious stage of a communicable disease (unless admitted under guidance), or exhibit behavioral problems that pose a risk to themselves or others.

IV. GENERAL POLICIES

Attendance

Scheduled days of participation may change in the course of this contract. However, to maximize benefit to the participant, attendance at the center needs to be planned and regular. The number of days scheduled is determined by the Physician Order Form. An addendum will be signed by the Responsible Party/Agent if changes are made in the days scheduled.

If a participant is asked to leave the center because of sickness or behavioral problems, or as a result of inclement weather, The Responsible Party/Agent or his/her designee must be available in this type of emergency to escort/transport the participant home in a timely manner, within the center's scheduled hours of operation.

Emergency Transportation

By signing this agreement, the participant and/or participant's Responsible Party/Agent grant permission to St. Ann to transport the participant to St. Agnes Hospital or another appropriate medical facility in the event of an emergency.

Weather

St. Ann intends to be open every schedule day during the winter months unless it clearly jeopardizes the safety and well being of participants and staff. Unlike in the past, we **will not** strictly follow the Baltimore County School System. We will be making an independent decision on a day-to-day basis. If weather dictates and the schools in the Baltimore County and/or Baltimore City are closed or opening late, we may be delayed in transporting or transporting participants home earlier than usual. Under some conditions, we will not be able to provide transportation.

If there is a question about whether the center is open, a message will be left on the St. Ann machine by 6:00 a.m. Also, any changes will be aired on WBAL radio. If we close early, we will use the emergency phone numbers to contact the care providers.

Participant:_____

Responsible Party/Agent: _____

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Personal Belongings
We request that participants keep a change of cloths at the center. It will be kept in a storage bin marked with their name. Clothes will need to be changed according to the season. Participant's outdoor clothing will be kept in a secure closet. All clothing that might be removed must be labeled. In addition, a supply of Attends or Depends may be requested for the participant's use.

Due to the number of participants, St. Ann staff cannot be responsible for lost or misplaced items. We recommend that no valuable items be brought to the center. Participants should not bring more than a couple of dollars into the center as a precautionary measure against loss/theft.

Outings
Activities include regular trips outside the center with appropriate supervision. Permission slips will be sent to the responsible party, and need to be returned to ensure opportunity to participate. Staff reserves that right to refuse participation if the needs of the participant or the program dictate.

There will be opportunities to go on outings should you choose to participate. Appropriate staff will supervise.

_____ I grant permission to participate and to be transported on such outings

_____ I do not grant permission.

Initials of participant/Responsible Party/Agent_____

Photography – Media Release
Occasionally photographs and videos are taken by staff and/or others for publicity and advertising purposes related to program and/or agency needs.
_____ I do **NOT** give permission to be photographed.

_____ I give permission to be photographed, videotaped.*

I,_____, do hereby give/grant St. Ann Adult Day Services, 3320 Benson Avenue, Baltimore, Maryland , 21227, and legal representatives the irrevocable right to use my name (or any fictional name), picture, portrait, photograph, or video tape in all forms and media in all manners, including composite, or distorted representations, for advertising, trade or any other lawful purposes. I understand that this name, picture, portrait, photograph, or video tape will be available for use on local television stations, newspapers, newsletters, billboards, busbacks, and/or various announcements, and therefore, am extending this right to St. Ann Adult Day Services at no charge or fee. I have read this release and am fully familiar with its contents.

Initials of the participant/Responsible Party/Agent_____ Date_____

Participant: _____

Responsible Party/Agent: _____

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Participant's Bill of Rights and Responsibilities.

The participant and/or the Responsible Party/Agent have reviewed the participant's bill of rights and list of participant responsibilities provided by St. Ann.

Participant Responsibilities
The participant/Responsible Party/Agent is responsible for the following:

1. Providing to the best of his/her knowledge, accurate and complete information about the present complaints, past illnesses and hospitalizations, medications and other matters relating to his/her health.

2. Reporting unexpected changes in his/her condition to the staff.

3. Making it known whether he/she clearly comprehends a contemplated course of action and what is expected or him/her.

4. Following both the treatment plan recommended by the Primary Care Physician and St. Ann treatment team responsible for his/her care and the organization's rules and regulations affecting participant care and conduct.

5. Being considerate of the rights of the other participants and staff and responsible for his/her behavior in the control of noise and smoking.

6. Being respectful of the property of others and of the program.

7. Assuring that the financial obligations of his/her attendance are fulfilled as promptly as possible.

Participant:_____

Responsible Party/Agent:_____

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The Signatures below absolves St. Ann Adult Day Services, Catholic Charities, the Board of Directors, and the staff of all liability, except in the event of injury arising from negligence on the part of Catholic Charities, its personnel, subcontractors, or volunteers.

_____ _____
Participant's Signature **Date**

_____ _____
Responsible Party/Agent Signature **Date**

_____ _____
Address (Zip Code) **Phone number**

I, _____ hold Power of Attorney or I am Guardian of the Property for _____ and am signing this agreement and services contract on his/her behalf. I agree to make payment for services rendered from _____ (what source of participant's income or assets).

I, _____ (Responsible Party/Agent) do not hold Power of Attorney for _____ but I am responsible for care, and agree to make payment for services rendered from my own funds.

_____
Representative of St. Ann Adult Day Services **Date**

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St. Ann Adult Day Services Intake Form

Date: _____

Name of Potential Participant: _____

Address: _____
Phone: _____ **D.O.B**: _____

Primary Caregiver: _____

Name of Inquirer: _____ **Relationship:** _____ (POA/Guardian/Other)
Address: (If different than above): _____
Phone Home: _____ Work: _____

How did you hear about us?

_____
_____

 # Of days per week participant would attend: _____

Pay Type:
Private ____ VA _____ Senior Care _____ Subsidy _____ Medicaid # _____

Medicaid Waiver _____

Type of Insurance(s) _____

Transportation:
Caregiver/Family _____ St. Ann _____
Wheel Chair ____ Walker____ Cane____
If Wheelchair, do you have a ramp? _____
Who will assist with curb-to-curb transportation? _____

Do you have medical and/or financial Power of Attorney?_____

Physician:_____

Diagnosis:_____
_____

Additional Information:
_____
_____
_____
_____

If the conversation ends short of admission, why? _____

SCHEDULED TOUR DATE: _____

Date Letter/brochure sent: _____
Date Tour confirmed: _____ Date Tour given: _____ Date Packet given: _____
Date Packet mailed: _____ Date follow-up occurred: _____

Completed By:_____
Participant:_____

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PERMISSION TO ADMINISTER MEDICINES

I hereby authorize the St. Ann Adult Day Services Nurse to dispense medications to _____, as ordered by his/her physician.

_____
Signature of Participant/Responsible Party

_____
Signature of St. Ann Adult Day Center Staff

_____
Date

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BILL OF RIGHTS

You will be informed prior to, or at the time of admission, of services available to the Center and of related charges.

You will be afforded the opportunity to participate in your plan of care.

You will be encouraged and assisted to exercise your rights as a participant and as a citizen, and may voice grievances to Center staff and/or outside persons, free from interference, coercion, discrimination or reprisal.

You will remain free from mental and physical abuse and from chemical and physical restraints, except as authorized in writing by a physician, or when necessary to protect you from injury to yourself and to others.

You will be assured to confidential treatment of your personal and medical records, and may approve or refuse their release to any individual outside the Center, except as required by third party payment contract. You will have access to your record in accordance with agency policy.

You will be treated with consideration, respect and full recognition of your dignity and individuality, including privacy in treatment and care of personal needs.

You will not be required to perform services for the Center that are not included for therapeutic purposes in your plan of care.

You may associate and communicate with persons of your choice and participate in activities and groups at your discretion, unless activity has been specifically included in your overall plan of care, agreed to at the time of admission.

The St. Ann Adult Day Services staff is required to report cases of abuse, neglect, self-neglect, or exploitation of participants to the Department of Social Services according to Family Law Article 14-302, annotated Code of Maryland

GRIEVANCE PROCEDURE:
You and/or your caregiver should direct all grievances to the Director of the Center. If issues of concern are not resolved to you satisfaction, they may be directed to the Director of Catholic Charities Division of Senior Services.

Participant:_____

Responsible Party/Agent:_____

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Financial Information Form

PARTICIPANT: _____

Address of Participant: _____

Phone: _____

PERSON RESPONSIBLE FOR BILLING:

Relationship_____

Address: _____

Phone: _____

***PLEASE ATTACH A COPY OF POWER OF ATTORNEY, ADVANCE DIRECTIVE, OR GUARDIANSHIP ORDER**

PAYMENT:
Medicaid_____ **Medicaid Waiver**_____ **Baltimore City/County Subsidy**_____

Veterans Administration-_____ **Private Pay**_____ **St. Ann Subsidy** _____

Comments:_____

_____

_____

STATEMENT OF INCOME/ASSETS:

Sources:_____

Amount of Income:_____

Real Property (Address and Value): _____

Assets (CD's and Bank Accounts):_____

Name(s) of Bank (ownership): _____

_____

TRANSPORTATION:
4. **Caregiver/Family** provides transportation:
one way- drop-off___ pick-up____ **both** ways_____

5. **St. Ann** provides transportation:
one way- drop-off ___ pick-up____ **both** ways____

SCHEDULED DAYS:
Mon. ___ Tue. ___ Wed. ___ Th. ___ Fri. ___ Sat. ___

I hereby certify that the information contained herein is true, correct and complete, to the best of my knowledge, information, and belief. If any information presented is found to be false, St. Ann retains the right to void my application for admission.

_____
Responsible Party/Agent

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PARTICIPANT SOCIAL HISTORY

Participant Name: _____
D.O.B.: _____

1. Participant was born and raised in the area of : _____
Lived in Maryland for how long? _____

2. Occupation of Participant's Parents Mother _____
Father _____

3. Number of Siblings and their names: (living/deceased)

_____ _____
_____ _____

4. Education/Years Completed: _____

5. Past Occupation/s of Participant: _____

6. Marital Status _____ Name of Spouse _____
How long (married/divorced/separated/widowed?) _____

7. Children

_____ _____
_____ _____

8. Grandchildren: _____ Great Grandchildren: _____

9. Hobbies/Interests – Past _____
Present _____

10. Member in Clubs/Organizations: _____

11. Speaks Foreign Language: _____

12. Religion: _____

13. Vacation Places & Travel: _____

Functional Status	Independent	Assistance Needed/ Assistive Device
Ambulating		
Transferring		
Wheeling		
Hearing		
Vision		
Eating/Feeding		
Toileting		
Bathing		
Dressing		
Oral Hygiene		
Housecleaning		
Manage Finances		
Legal/Personal		
Telephone		

Comments: _____
_____