

**Enrollment Agreement**

1. Consent is given for **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** to be enrolled in the Adult Care Center of Roanoke Valley, Inc.

**2**. I agree that only Adult Care RN/MT are to administer medications. I will not carry medications on my person while attending ACCRV. I consent to first aid emergency care as needed.

**3**. I understand that fees are subject to change. (The current daily rate is $80.00 per day. Baths/Shower is $24.00 per session). **Pre-payment for days attending is required.** Participant’s account will not be charged for days that Participant does not attend. Any money paid in advance will be refunded if the participant no longer attends the ACCRV or it may be donated to ACCRV per request of the payor. Refunds are made within 30 days after the last month attended.

4. I understand that I am responsible for all fees not paid by insurance, scholarships or other funding sources. (Scholarship assistance is available to eligible participants; however, any such scholarship grants in aid are not guaranteed.)

**5**. I understand and agree that the Adult Care Center of Roanoke Valley, Inc. is not responsible for lost, damaged or misplaced items.

6. I give consent to take pictures/videos of the participant for promotional and community awareness of the Adult Care program.

**7**. I understand that there is a minimum of two days per week of attendance and agree to the attendance policy unless I give a two-week prior notice of absence. I understand that I will make up any missed days that week.

8. I understand that I will be charged a late fee if the participant is not picked up by the closing time of 6:00pm. The fee will be $10.00 per every 5 minutes after the closing time. I understand that the funding source (example: Medicaid, VAMC benefits, etc.) will not be responsible for payment of this fee and that it will be billed directly to me. I understand that if I do not cancel the transportation, I will be responsible for the fee.

9. I understand that it is the caregiver’s responsibility to provide the Adult Care Center with an annual history and physical. (RN/staff will notify caregiver by letter or pending annual renewal date)

10. Caregiver will provide center with correct medications per physician order at least 1 day prior to start date. A completed medical report will be provided prior to enrollment. The caregiver will be notified by staff or RN when the annual physical is due.

11. I understand that any threatening or abusive behavior toward staff or other enrollees or other serious risk to health, safety or welfare for myself or other participants will result in immediate discharge from the program. Failure to abide by the terms of this Enrollment Agreement may also result in dismissal from the program.

12. I understand that either myself, family members or personal representatives can appeal a center-initiated discharge.

13. I understand that the Center will give 30 days notice of increase of charges.

14. I understand when there is a transfer of ownership, closing of the center or participant discharge occurs any refund due the participant will be given by the center within 30 days. Any fees due from the participant will also be satisfied.

15. I understand that I will receive a monthly statement or itemized receipt of the participant’s account. Some programs are paid by a 3rd party such as the Veterans Administration, Local Office on Aging, Medicaid or Medicare Advantage plans, and Sue Nutter Scholarship fund.

**The Adult Care Center agrees to provide the following services:**

1. Individualized plans of care focused on medical and behavioral needs.
2. A daily nutritious hot meal and two wholesome snacks; morning and afternoon.
3. Regular health monitoring and supervision of medication administration.
4. Leisure activities, including hobbies, crafts, outings, music and other entertainment.
5. Physical exercise programs to promote wellness and strengthening.
6. Accommodations for physician ordered physical, speech, or occupational therapies to be provided on site by the individual/s professional therapist.
7. Life enrichment programs including recreational, educational, and social activities.
8. Support through education and resource development for caregivers and families.
9. Should the center’s administrative staff decide a discharge from the program is necessary, (for reasons other than those which cause for immediate discharge from the program), participants, family members or personal representatives will be notified at least 30 calendar days prior to the actual discharge date.

Participant/Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s relationship to participant (e.g. daughter, power of attorney, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by Adult Care Center of Roanoke Valley, Inc.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11/06/2024 JMG