Mailing Address Application Only:

Buncombe: 5 Oak St, Asheville, NC 28801

Henderson: 55 N Hillside Rd, Hendersonville NC 28791

Mountain Aging Partners

Completed paperwork can be emailed to: ADINTAKE@MAPNC.ORG

Please put to the attention of Buncombe or Henderson in subject line.

Circle: ***Buncombe County Center*** ***Henderson County Center***

Important – Please read all Information below

Welcome to Mountain Aging Partners Adult Day Services

The two primary purposes of Mountain Aging Partners Adult Day Services are to serve our participants by enhancing their quality of life, and to help their caregivers keep them at home as long as possible by providing caregiver respite. If you decide that we can help you, please complete the attached application packet. As soon as we receive the completed paperwork, ***along with the $40 application fee***, we will schedule your family member for a four-hour Orientation Day, **from 10:00 a.m. to 2:00 p.m.** If that day is successful, as most of them are, we will enroll your family member at the end of that period. Please plan to return at 1:30 p.m. to complete enrollment forms. *****Please Note – the charge for the 4-hr. Orientation Day is the same as for a regularly scheduled full day at the day care rate due to the one-on-one staffing needed during that time to provide additional personal attention.***

A Few Reminders…

* Please **mark all clothing items** that your family member wears to the Center (including underwear if incontinence is a possibility). This also includes coats, which are easily confused during busy pick-up times. **Keeping a full change of clothing at the center, including underwear and socks, is also helpful.** If your family member uses or prefers a *special type* of undergarment, we may not have them in stock, so please bring a supply for us to keep in their clothing bin.

* Please discourage your family member from bringing a pocketbook, money, cell phones, or valuables of any kind to the Center. We cannot be responsible for them, and they can quite easily be misplaced or lost.

* North Carolina regulations require that ***all medications have a doctor's order and be in a "prescription container clearly labeled with the Participant's full name, name and strength of medication, and dosage and instructions for administration".***

* Our Buncombe and Henderson centers are open Monday through Friday from 8:00 AM to 5:30 PM. We offer full days, and morning or afternoon partial days. If interested in partial days, please let us know. Lunch is **not** included with **partial days**. Billing is done on a monthly basis for all days **enrolled** the previous month.

Below is a checklist to help guide you through completion of the application packet:

- ☐ Complete Application for Enrollment & Social/Lifestyle History
- ☐ Complete Adult Day Services Health Form
  - Caregiver completes Section 1.
  - Physician **reviews** Section 1 and completes & **signs** Section 2.
- ☐ Sign Consent and Authorization Form ***and have witnessed***.
- ☐ Sign Waiver and Release of Liability
- ☐ Return packet to MAP Adult Day Services with $40 application fee.
- ☐ Bring **2 ORIGINAL** DNR / MOST Forms if applicable.
- ☐ Bring Insurance cards to be copied.
- ☐ Bring copy of HCPOA or POA if applicable.

A Caregiver Support Services staff member will contact you, the caregiver, as soon as possible in order to schedule the **four-hour** *first-day.***

Mountain Aging Partners Adult Day Services
APPLICATION FOR ENROLLMENT

For office use only:
Participant I.D. #____

Non-refundable Application Fee $40.00 __(check when received)
Re-enrollment Application Fee: $20.00 __(check when received)

Circle all that apply: *Mountain Explorers (Buncombe only)* *Day Care/Day Health - Buncombe / Henderson*

Applicant's full name: _____ Preferred Name: _____

Birth date: _____ Male _____Female_____ Marital Status: _____

Address: _____

Telephone: _____Last 4 of SS # : _____

Caregiver E-mail Address: _____

Reason for interest in coming to this program: _____

Has Applicant had previous experience in a Day Program? Yes No

Living with whom: _____ Relationship_____

It is ***VERY*** important that we are able to contact someone during the day if necessary. Please list at least two people to contact, and the number(s) at which they can be reached throughout the day. The **first person** should be the **primary caregiver** (closest relative or person he/she resides with).

1) Name: _____Relationship: _____

Address_____

Home phone: _____Business phone: _____ Cell/Beeper#_____

---

2) Name: _____Relationship:_____

Address_____

Home phone: _____ Business phone: _____ Cell/Beeper # _____

Do you plan to provide your own transportation? Yes No *(if no, a Transportation Needs Assessment will be completed)*

Anticipated days of enrollment: Mon. Tues. Wed. Thurs. Fri. *(Circle days that apply)*

Approximate time of arrival and departure daily: Arrival _____ Departure _____

Signed_____ Date_____

Please list below any additional family members/friends that may be contacted if neither of the persons listed on the front can be reached.

Name: _____Relationship:_____

Address_____

Home phone: _____ Business phone: _____ Cell/Beeper # _____

Name: _____Relationship:_____

Address_____

Home phone: _____ Business phone: _____ Cell/Beeper # _____

Primary Care Physician and/or Physician Completing Health Form:

Name: _____

Address_____

Business phone: _____ Fax # _____

May we contact your physician as needed? (Circle One) YES NO

Revised 9.30.25

MOUNTAIN AGING PARTNERS ADULT DAY SERVICES

Buncombe County Center / Henderson County Center

SOCIAL / LIFESTYLE HISTORY

Name of Participant_____

Past Occupation (s): _____

Does Participant have a military past? ***YES / NO*** *(circle)* **Branch**: _____

Special experience/recognition: _____

Highest level of Education/Diploma: _____

Club or Civic Organization Involvement: _____

_____

Religious preference / involvement: _____

Primary Language: _____ **Other Languages Spoken:** _____

Race: *(circle)* African American Asian Caucasian Native American Hispanic Other Unknown

Most important factor(s) in life (such as occupation, religion, family, personal interests, hobbies, etc.):

_____

_____

_____

Name and relation of anyone that the participant may talk frequently about:

Name	***Relationship***	***Name***	***Relationship***

Pets: Does or did your loved one have a pet that was important to them? **YES / NO**

If Yes: What kind of pet(s)? _____ Pet's Name(s) _____

Does he/she enjoy being around small children? ***YES / NO*** (please circle)

Sociability: He/she enjoys **large** groups / small groups **/ both** / **neither** (please circle)

Comments: _____

_____

Past and/or present hobbies, sports, areas of interest: (please check all that apply)

Cooking		**Gardening**		**Exercise**		**Movies**		**Crocheting**	
Sewing		**Woodworking**		**Animals**		**Flower Arranging**		**Travel**	
Quilting		**Reading**		**Music**		**Card Games**		**Table Games**	
Bible Study		**Singing**		**News**		**Bingo**		**Sports**	
Arts		**Dancing**		**Crafts**		**Puzzles**		**Board games**	

Habits and patterns: Does your loved one have any unique patterns or habits that would be helpful for us to know about? (For example, they always take a walk after lunch, they are used to having "tea" in the afternoon, or they like to read the paper in the morning, etc.):

_____

_____

Eating/Drinking habits:

Preferred/favorite beverage? _____

Preferred/favorite foods? _____

Foods strongly disliked? _____

If coming for a full day, will he/she eat breakfast at home? ***YES / NO (***please circle)

Resting Habits: Does he/she normally take a nap during the day? ***YES / NO*** (please circle)

Current Tobacco Use: (please circle) None Cigarettes Cigars Pipe Snuff/Chewing Tobacco

As we care for your loved one, what are the most important things we should know or do to make his/her time in the program successful?

_____

_____

_____

Additional Information/Comments:

_____

_____

_____

IF YOU HAVE ANY PICTURES THAT YOUR LOVED ONE MIGHT ENJOY SHARING, PLEASE BRING COPIES (NOT THE ORIGINALS) – IT HELPS STAFF GET TO KNOW THEM.

THIS FORM WAS COMPLETED BY: _____

THANK YOU FOR TAKING THE TIME TO HELP US GET TO KNOW YOUR FAMILY MEMBER BETTER

BUNCOMBE COUNTY TELEPHONE (828) 277-3399/ FAX (828) 277-4855
HENDERSON COUNTY TELEPHONE (828) 697 -7070/FAX (828)697-8855

Mountain Aging Partners

ADULT DAY SERVICES HEALTH FORM

Buncombe County Center ***Henderson County Center*** **(PLEASE CIRCLE)**

NAME_____DATE OF BIRTH_____

Most recent date seen by physician_____

Section 1

CAREGIVER - PLEASE COMPLETE FRONT AND BACK OF SECTION 1 *FOR REVIEW BY PHYSICIAN*

History of Disease/ Chronic Condition	*Current Condition*	*Past History*	*If MARKED, please provide further detail below*
• Anemia	_____	_____	_____
• Arthritis	_____	_____	_____
• Cardiac	_____	_____	_____
• Cancer	_____	_____	_____
• Diabetes	_____	_____	_____
• Effects of Stroke	_____	_____	_____
• Epilepsy/Seizures	_____	_____	_____
• Gastro-Intestinal	_____	_____	_____
• HIV	_____	_____	_____
• Hearing	_____	_____	Does he/she wear a hearing aid? Y N _____
• High Blood Pressure	_____	_____	_____
• Respiratory/Pulmonary	_____	_____	_____
• Tuberculosis	_____	_____	_____
• Urinary Tract	_____	_____	_____
• Vision	_____	_____	Does he/she wear glasses? Y N _____
• Dementia	_____	_____	_____

Does this person have any psychiatric or behavioral concerns? If so, please comment on nature, severity, and treatment needs: _____

Please describe any other disease or condition not mentioned above:

_____

_____

Does this person require constant supervision to ensure that he/she does not do harm self, others/property Yes _____ No_____ or frequently seek an exit from the facility? Yes _____ No_____

Do you recommend any restrictions on physical activities such as walking, exercise, etc.? Yes_____ No _____
☐ Bending ☐ Walking ☐ Exercise

Does this person have functional limitations? If yes, please circle **Neck Leg Arm Hand Foot Other**

PARTICIPANT NAME _____

Does this person use an assistive device? If yes, please circle: **wheelchair walker cane brace prosthesis**

Does this person require assistance in the bathroom (sitting, dressing, wiping, catheter, colostomy, etc.…)?
Yes ____ No ____ If Yes, please explain: _____

This person: Eats independently? Yes _____ No _____ Needs food cut up? Yes _____ No _____
Needs prompting? Yes _____ No _____
Please list (PRINT) **ALL** medications the person is now taking, with dosages and times medications are to be taken, attach additional sheet if needed:

Medication	**To Be Given at Center (circle one)**	**Dosage**	**Amount and Time to be given**
Example: Glucophage	***Y / N***	***500mg***	***1 in am, 2 at noon and 1 at supper***
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		
	Y / N		

Allergies or reactions: ☐ **No known allergies** ☐ Insect/Bee sting ☐ Food ☐ Medication ☐ Perfumes/Lotions
☐Animals ☐Latex *If any are checked, please specify:* _____

If participant has a severe allergy to bee stings, does he/she have an Epi Pen? Yes ____ No ____

If severely allergic, it is the responsibility of the caregiver to provide the center with a non-expired Epi Pen to prevent an adverse reaction to a sting. If an Epi Pen is not available in the event of a severe allergic reaction, the center's staff will contact Emergency Responders.

Please provide the best person/phone number for medication clarification:

Caregivers must provide all medications in properly labeled prescription bottles. I understand if the medication is not provided by the caregiver or if the medication is not in properly labeled prescription bottles, nursing staff will not be able administer the medication.

In signing this document I consent to Emergency Medical Treatment for the enrolled participant if/when deemed necessary by the Adult Day Services staff.

SIGNATURE OF CAREGIVER: _____

SIGNATURE OF PHYSICIAN: _____

FOR OFFICE USE ONLY:

Health Care Staff Member has reviewed this form: _____ *Staff initial* _____ *date*

Health Care Staff Member has followed up with caregiver if necessary: _____ *Staff initial* _____ *date*

PARTICIPANT NAME _____

MOUNTAIN AGING PARTNERS ADULT DAY SERVICES HEALTH FORM
Buncombe County Center ***Henderson County Center*** ***(PLEASE CIRCLE)***

Section 2
PHYSICIAN MUST COMPLETE
FRONT AND BACK OF SECTION 2 AND SIGN PAGE 4. _PHYSICIAN_ MUST VERIFY INFORMATION IN SECTION 1 AND SIGN PAGE 2.

NUTRITION
Any special dietary requirements? Yes____ No _____ ☐ Diabetic ☐ Puree ☐ Mechanical Soft
Other: _____ If diabetic, provide specific details _____
Please note: Standard diet for our participants is considered low fat and low salt.

Wears dentures (upper/lower?) Yes____ No _____ Is at risk for choking? Yes _____ No _____
Has frequent skin breakdown? Yes ____ No _____ Has had a recent change in weight? Yes ____ No ____

VITAL SIGNS (please supply for baseline)
B/P_____ Pulse_____ Resp _____ Temp _____

Height _____ Weight _____ Blood Sugar Level _____

FREE OF CONTAGIOUS DISEASE
Do you feel this participant is at risk for TB? Yes ____ No _____ If yes, TB test is advised

TB Test Results (optional): Positive _____Negative _____ Date of Test: _____

Comments: _____

Does the participant currently have a VRE/MRSA (Methicillin-Resistant Staphylococcus Aureus) colonization/infection:_____

ADVANCE DIRECTIVES
Does patient/participant have a current DNR (Do Not Resuscitate) order or M.O.S.T. form? Y____ N____
(This is NOT their Living Will – it is a bright orangey-yellow or bright pink form signed by their doctor.)

If yes, please provide 3 *ORIGINALS* to the family: one to give to EMS if necessary; one to remain at Adult Day Center; and one for patient/participant's home, to be placed on their refrigerator.

Currently Under Hospice Care? Y_____ N_____

Additional Comments:
_____

Participant Standing Orders for Medication and Treatment

*Participant Name:*_____

****

1. **PAIN:** Acetaminophen 1000 mg po every 6 hours PRN pain, do not exceed 3000 mg in 24 hours.
2. **FEVER>100:** Acetaminophen 1000 mg po every 6 hours PRN fever. Report to care giver.
3. **BRUISING:** Arnica Cream, apply thin layer to affected area and massage gently as soon as possible after minor injury with intact skin. Repeat 3x daily PRN.
4. **SIMPLE COUGH OR CONGESTION:** Guaifenesin syrup 200 mg po every 4 hours PRN cough. NOT TO EXCEED 4 DOSES IN A 24 HOUR PERIOD. Report to care giver.
5. **DRY EYES:** Any OTC artificial tears/lubricant, 1-2 gtts PRN dry eyes, repeat every 1 hour as needed.
6. **INDIGESTION:**
   *Calcium Carbonate tablet (Tums or equivalent) 1-2 tabs po qid prn indigestion. -OR-
   *Aluminum hydroxide/magnesium hydroxide suspension (Maalox/Mylanta or equivalent) 10-20 ml po qid prn.
7. **DIARRHEA:** Metamucil 1 tbsp. in 8oz of water or 2 wafers every day prn diarrhea (after 2nd episode). *If accompanied by signs of illness or after 2nd unformed stool, caregiver will be called and the participant will be sent home.*
8. **CONSTIPATION:** Miralax 17g PO once a day PRN constipation. If Miralax ineffective after 6 hours can try saline enema (Fleet saline enema 4.5 oz.) PR x 1. Impaction may be removed digitally PRN. At any sign of bleeding/pain, the procedure must be stopped. Repeated episodes should be referred to PCP.
9. **SKIN TEAR:** Clean area with normal saline or wound cleanser and wipe with gauze. Use cotton swab to push skin flap back in place. Apply skin barrier wipe and allow to dry completely to intact skin around skin tear. Apply wound closure strips (e.g. Steri Strips) to secure skin flap in place. Cover with silicone foam dressing. Secure with roll gauze bandage and tape; avoid tape to fragile skin. Change dressing every 7 days or PRN for drainage saturation into dressing. If purulent drainage or erythema develop, consult PCP.
10. **MINOR BURN:** Immediately immerse the burn in cool tap water or apply a cool, wet compresses for approximately 10 minutes. Apply A&D ointment to the affected area.
11. **FOR URTICARIA, RASH, ITCHING, REACTION TO BEE STING OR INSECT BITE:**
    *Hydrocortisone 1% apply to intact skin every 12 hours for 3 days then stop.
    *Loratadine 5 mg per 5 mL X 1, PRN urticaria or reaction to bee sting. Notify family and physician if problem persists.
12. **CBG's PRN**: for signs and symptoms of Hyperglycemia or Hypoglycemia. For BGL<60 mg/dL, give OJ if patient is alert. If participant is not alert call 911.
13. **ACUTE SOB, CHEST PAIN OR ALLERGIC REACTION:**
    Oxygen 2-4 L/Min. per Nasal Cannula PRN and call care giver and/or 911 as per advanced directives.
14. **When 911 is called to transfer a participant to hospital for CHEST PAIN:** give ASA 325 mg po, if participant is able to take po.
15. If there are any other OTC medications that are to be given, please specify: _____

I certify that I have examined the above-named person and have reviewed their health history and find them physically able to participate in an adult day health activity program. I also give my approval to the Adult Day Services Staff to administer routine medications per family request as well as: "Standing Orders for Medication and Treatment" listed above.

Physician's Signature: _____ Printed Name: _____ Date: _____

Physician's Address: _____

Telephone: _____ Fax: _____

Family's Hospital preference (when applicable): ☐ Mission Health Systems ☐ VA ☐ Pardee ☐ Advent

Mountain Aging Partners

Buncombe County Center ***Henderson County Center*** **(please circle)**

CONSENT FORM for ADULT DAY SERVICES

PARTICIPANT NAME: _____

In consideration of services and/or health care treatment to be provided, the undersigned acknowledges, authorizes and agrees to the following:

1. CONSENT FOR CARE AND TREATMENT.

I voluntarily consent to admission to Mountain Aging Partners, Inc. ("Mountain Aging Partners") for adult day services.

Physician-Directed Services: I hereby authorize and direct Mountain Aging Partners' medical and other clinical staff to perform or administer treatment, medications, procedures, examinations, and/or injections under the direction of my physician. I understand I have the right to be informed by my physician(s) of the nature and purpose of any proposed treatment regimen or procedure and any available alternative methods of treatment, together with an explanation of the associated risks/precautions. This form is not a substitute for such explanations, which my physician(s) are responsible to provide according to recognized standards of medical care.

Other Services: I hereby authorize and direct Mountain Aging Partners' medical and other staff to provide services that are requested by me or my Responsible Party and that in their best judgment are necessary and in my best interest.

2. CONSENT FOR RELEASE OF MEDICAL INFORMATION/TRANSMISSION OF INFORMATION.

I consent to Mountain Aging Partners furnishing medical information (except psychotherapy notes), including any information relating to identity, diagnosis, prognosis or treatment of any medical condition, including psychiatric disorders and alcohol or drug abuse, results of HIV testing, diagnosis of Acquired Immune Deficiency Syndrome (AIDS) and/or other communicable diseases, relating to this episode of treatment for the purposes of treatment, payment and health care operations to the following persons, facilities or entities:

A. other health care providers for treatment purposes, continuity of care and follow-up; to my referring physician, attending physician, primary care physicians, consulting physicians, and hospital-based physicians, as well as, to any licensed physician, health care agency, other clinician, or medical or nursing facility to which I am referred or transferred for further medical care. Information may be released to other agencies such as medical equipment and infusion therapy companies for provision of my care. I understand that this information will only be provided when required to ensure appropriate coordination of medical services on my behalf;

B. any insurance company, managed care company, Medicare, Medicaid, workers' compensation or other payor that I identify as providing benefits to me or to Mountain Aging Partners, any governmental or charitable agencies or their agents, and any professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my medical care expenses;

C. groups or their agents identified in the Assignment of Insurance Benefits form;

D. any person or external review agency involved in reviewing, authorizing, or processing my eligibility for health insurance coverage, payment of benefits or billing compliance for the payers that I identify;

E. emergency transport services that transport me to or from Mountain Aging Partners;

F. regulatory, accrediting, and quality review persons or agencies such as Medicaid, and NC Department of Health and Human Services, who monitor Mountain Aging Partners' compliance with regulatory requirements and assuring quality outcomes for participant care.

G. family members or persons that I or my representative identify as involved in my care. This consent does not authorize the release of a copy of my medical records to family members or other persons involved in my care;

H. persons at my home or other designated location or number that I provide (including telephone, e-mail

or mail for follow-up calls or messages to me or my representative) concerning appointment reminders or request for a return call; and I understand that Mountain Aging Partners' operations may include medical, technical, or clinical students and/or trainees which may assist licensed staff in the provision of care, and that these individuals may be part of my care team with the approval of, and under the guidance and supervision of Mountain Aging Partners staff.

I understand that Mountain Aging Partners will take reasonable precautions to protect the confidentiality of my health care information. I also understand that my name, location and a one-word description of my general condition (fair, stable, good, serious, etc.) may be released, if requested, to callers and/or visitors. I understand that I may restrict the information or to whom it is disclosed or opt out of such disclosure.

3. CONSENT FOR TAKING PICTURES, AUDIO AND/OR VISUAL RECORDINGS.

I consent to Mountain Aging Partners, its agents, employees, and other parties under contract with Mountain Aging Partners taking, developing, printing, and copying photographs/video recordings of myself or parts of my body, and/or audio recordings regarding my treatment FOR THE PURPOSE OF MEDICAL DOCUMENTATION. I understand that such photographs/audio/video recordings may be used to document and support the clinical course of my care, third party reimbursement, or staff education. This consent for such media shall be continuing at all times during this episode of care unless revoked in writing by myself or authorized representative. Finally, such media will be placed in my medical record.

4. ADVANCE DIRECTIVES (*for persons 18 years of age or older*).

I have received a copy of "Medical Care Decisions and Advance Directives: What You Should Know." I understand that Mountain Aging Partners maintains policies and procedures to protect my right to make health care decisions. This includes the right to review my plan of care, accept or refuse treatment and the right to formulate advance directives. I understand that some medical services or procedures may not be provided through Hospice services, including advanced life support. I acknowledge my right to request and receive copies of advance directive policies and procedures at any time.

5. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

I have reviewed or been given the opportunity to review Mountain Aging Partners' Notice of Privacy Practices that describe how my health information is used and shared. I understand that Mountain Aging Partners has the right to change this notice at any time. If desired, I may obtain a current copy of the Notice by contacting Mountain Aging Partners' Intake Office for the services that I am receiving.

As the undersigned, I certify that I have read the foregoing and that I have received a copy of the foregoing. I have been encouraged to ask questions if I do not understand. I voluntarily sign this form and understand that I may revoke consent at any time by notifying Mountain Aging Partners in writing, except to the extent action has already been taken based upon this consent, including the disclosure of information to third party payors to seek payment for the care and treatment provided to me. Unless revoked by me, this consent remains in effect for two (2) years from the date written below. I certify that I am the participant or am duly authorized by the participant as the participant's general agent or representative (Responsible Party) to execute the foregoing and accept its terms.

_____ Dated this _____ day of _____, 20_____

(Participants Signature)

_____ _____

(Signature of Participant's Agent or Responsible Party) (Witness)

Responsible Party. I am acting on behalf of the participant and authorize the provision of services and release of medical information as directed above. The participant has granted me the authority and is giving me permission to act on their behalf. My relationship to the participant is_____.

I am acting on behalf of the participant because_____.

Mountain Aging Partners, Inc.
Waiver and Release of Liability

To protect the health and safety of its Adult Day Care participants during the COVID-19 pandemic, Mountain Aging Partners, Inc. ("Mountain Aging Partners") is following federal, state and local guidelines for its Adult Day Care program ("the Program"). In addition, Mountain Aging Partners has developed internal processes and procedures to maintain a clean environment, promote social distancing, limiting the number of participants and continually assessing the health of its participants, staff and volunteers. Regardless of all the measures implemented, I understand and recognize there is still a risk to the Program participants, particularly due to the possibility of community spread of the COVID-19 virus even from individuals who are asymptomatic.

In consideration of the risk of injury or illness while participating in the Program, and as consideration for the right to participate in the Program, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Program, and do hereby release and forever discharge Mountain Aging Partners, Inc., and its staff, volunteers, agents, attorneys, board of directors, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Program, including traveling to and from this Program.

I am voluntarily participating in the Program and I am participating in the Program entirely at my own risk. I am aware of the risks associated with traveling to and from as well as participating in the Program, which may include, but are not limited to, physical or psychological injury, pain, suffering, illness, temporary or permanent disability, economic or emotional loss, and death. I understand that these injuries, illness or outcomes may arise from my own or others' negligence, conditions related to travel, the condition of the Program facility or the condition of other Program participants. Nonetheless, I assume all related risks, both known or unknown to me, of my participation in this Program, including travel to and from this Program.

I agree to indemnify and hold harmless Mountain Aging Partners against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If Mountain Aging Partners incurs any of these types of expenses, I agree to reimburse Mountain Aging Partners.

I acknowledge that I have carefully read this "waiver and release" and fully understand that it is a release of liability. I expressly agree to voluntarily give up or waive any right that I otherwise have to bring a legal action against Mountain Aging Partners for personal injury or property damage.

I certify that I am currently in good health and will meet all of the Program's requirements for participants, including having no fever, no symptoms of any illness, no close contact with anyone with a confirmed case of COVID-19, not currently being required to quarantine/self-isolate, and I have been following the CDC recommended precautions of wearing a mask/social distancing.

_____ Dated this_____day of _____, 20_____
(Participants Signature)

_____ _____
(Signature of Participant's Agent or Responsible Party) (Witness)

Responsible Party. I am acting on behalf of the participant and authorize the provision of services and release of medical information as directed above. The participant has granted me the authority and is giving me permission to act on their behalf. My relationship to the participant is _____. I am acting on behalf of the participant because_____.

Mountain Aging Partners

	"Never" (0)	"Rarely" (1)	"Sometimes" (2)	"Quite frequently" (3)	"Nearly always" (4)
Do you feel…?					
That because of the time you spend with your relative that you don't have enough time for yourself?					
Stressed between caring for your relative and trying to meet other responsibilities (work/family)?					
Angry when you are around your relative?					
That your relative currently affects your relationship with family members or friends in a negative way?					
Strained when you are around your relative?					
That your health has suffered because of your involvement with your relative?					
That you don't have as much privacy as you would like because of your relative?					
That your social life has suffered because you are caring for your relative?					
That you have lost control of your life since your relative's illness?					
Uncertain about what to do about your relative?					
You should be doing more for your relative?					
You could do a better job in caring for your relative?					

Guidelines for scoring:

- 0-10: no to mild burden
- 10-20: mild to moderate burden
- >20: high burden