

Greene County Senior Center

P.O. Box 759
1301 Silver Drive
Greensboro, Ga. 30642
706-453-7463

Mary Brown, Manager

GUIDELINES FOR SENIOR CENTER PARTICIPATION

1. You must be sixty years of age or older, or the spouse of a participant sixty years of age or older, or a disabled relative living in the house of a participant sixty years of age or older. In the case of senior centers located within senior housing, disabled adult residents may attend the center.
2. You must be willing to attend a senior center and participate.
3. You must be able to communicate your needs and to perform routine activities of daily living independently. This includes eating, toileting, and getting to the van. The first orientation to the facility and meal service will be provided, after the orientation the participant must be able to navigate within the center independently.
4. You must be able to function, after orientation and with reasonable accommodation, in the existing facility with existing staffing (the senior center cannot provide one on one assistance with activities of daily living).
5. You must be independent in ambulation, with or without assistive devices, and able to transfer without assistance.
6. You must be continent or able to manage incontinence successfully and independently (i.e., able to manage your own Depends or incontinency pads).
7. For your own safety and the safety to your fellow participants, no one exhibiting confusion or a tendency to wander may attend a senior center . If such a condition proves treatable or otherwise reversible , participants may be reassessed for appropriateness for senior center attendance by the senior center director.
8. You must comply with established , written center and agency policies to include smoking , meal and transportation reservation and contributions . Contributions are strongly encouraged to help support senior center programs.
9. You must provide adequate information for assessment and answer assessment questions independently. Information required for verification on need of home delivered meals is written notification from a doctor or social service agency,
- 10 Any behavior which interferes with the ability of other eligible participants to take full advantage of senior center or home delivered meals programming may result in suspension and/or termination of services. This may include instances of poor personal hygiene, disruptive behavior, or no longer being home bound. No substance abuse, violence, or threat of violence, physical or verbal, will be tolerated under any circumstances. You may not come to the center under the influence of alcohol or consume alcohol while there.

I have read the above guidelines and agree to follow them.

Staff Signature _____ Date _____

Client Signature _____ Date _____

Greene County Senior Center

MEMBER INFORMATION

Date: _____

FULL NAME:			
ADDRESS:		City	State Zip
TELEPHONE: ()		REFERRED BY:	
GENDER IDENTITY:		RACE:	
DATE OF BIRTH:			
PHYSICIAN'S NAME:			
PHYSICIAN'S PHONE:			
DO YOU HAVE ANY ALLERGIES (FOOD, ENVIRONMENTAL, OR MEDICATION) THAT WE NEED TO KNOW ABOUT?			
HOSPITAL PREFERENCE:			
IF YOU WOULD LIKE US TO KEEP A LIST OF YOUR MEDICATIONS, PLEASE LIST THEM BELOW			
2 EMERGENCY CONTACTS:			
NAME:		RELATIONSHIP:	
ADDRESS:		City	State Zip
HOME PHONE: ()		WORK PHONE: ()	
NAME:		RELATIONSHIP:	
ADDRESS:		City	State Zip30014
HOME PHONE: ()		WORK PHONE: ()	

Revised February 2015

GREENE COUNTY SENIOR CENTER

CLIENT NAME: _____

DATE OF BIRTH: _____

LIST OF MEDICATIONS:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, give the Greene County Senior Center staff permission to seek medical attention for me, if needed, and to give a copy of this form to the medical care provider.

HOLD HARMLESS AGREEMENT

I hereby release, absolve, and hold harmless the Greene County Senior Center and the Greene County Board of Commissioners, as well as representatives, employees, successors and assigns, for any and all claims for personal injury, property damage, death or other damages sustained while participating in county programs or while traveling in a county vehicle. I further release those parties named above from any liability, claim suit, or other action related to the preservation, release, or failure to release the medical information contained within.

Client Signature: _____ Date: _____

If the client is physically unable to provide signature, the client may designate a personal representative to sign this form on their behalf

Personal Representative: _____ Date: _____

Relationship to Client: _____

Witness: _____ Date: _____

ADDITIONAL INFORMATION

Are you diabetic? Yes _____ No _____
Are you visually impaired? Yes _____ No _____ Are you hearing impaired? Yes _____ No _____
Are you a veteran? Yes _____ No _____
Living Situation: Alone: _____ With Spouse: _____ With Other Family: _____ Other: _____
Have you ever attended Greene County Senior before? Yes: _____ No: _____
Will you need transportation to the center? Yes: _____ No: _____
What days will you be attending the center? M: _____ T: _____ W: _____ Th: _____ F: _____

(For homebound) DIRECTIONS TO HOME: _____

DATE/UPDATE _____

STAFF INITIALS _____

Division of Aging Services HCBS Income Worksheet

Completed for _____

Part A: Household Information

Number in Household _____

List the name of each household member:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Part B: Income Information

Sources of Total Monthly Income

Applicant/Recipient's Statement of Amount

- | | |
|---|----------|
| 1. Wages or salary (earned income) | \$ _____ |
| 2. Net wages from self-employment (farm/non-farm) | _____ |
| 3. Social Security pensions, survivor benefits, disability payments | _____ |
| 4. Public Assistance (TANF, SSI, General Assistance) | _____ |
| 5. Dividends, interest, royalties | _____ |
| 6. Private pensions, annuities, other retirement benefits | _____ |
| 7. Unemployment compensation | _____ |
| 8. Workers compensation | _____ |
| 9. Alimony | _____ |
| 10. Child support | _____ |
| 11. Veteran's pension | _____ |
| 12. Military allotment | _____ |

Total Monthly Household Income \$ _____

(Minus) Cost of Out-of-Pocket Health care, Rx, OTC meds, CCSP cost share - _____

(Equals) Adjusted Monthly Household Income = \$ _____

Part C Calculations

1. Adjusted monthly household income \$ _____

multiplied x 12 =

Total Annual household income \$ _____

2. Determining the Fee

Unit Cost for _____ = \$ _____ per _____
(enter name of service #1)

Unit Cost for _____ = \$ _____ per _____
(enter name of service #2)

Unit Cost for _____ = \$ _____ per _____
(enter name of service #3)

3. Per cent of cost share : _____ % from fee scale

4. Amount of cost share : Service 1 \$ _____ Service 2 \$ _____ Service 3 \$ _____

Completed by _____

Date _____

Georgia Department of Human Services



Name of
Individual/Consumer/Patient/Applicant

Date of Birth

ID Number Used
by

ID Number Used
by

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize:

(Name of Person or Agency Requesting Information)

(Address)

to obtain from:

(Name of Person or Agency Holding the Information)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

- ☐ ninety (90) days unless I specify an earlier expiration date here: _____ (Date)
- ☐ One(1) year.
- ☐ The period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness)

(Title or Relationship to
Individual)

(Signature of Parent or other legally Authorized
Representative, where applicable)

(Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

SENIOR CENTER PARTICIPANTS RIGHTS

Since you receive or have requested social services from our agency, you have the following rights:

1. The information you share with your worker is private or "confidential." What you tell your worker cannot be shared with anyone besides Department of Human Resources or agency staff, unless you give them permission. Official program staff will also be reviewing your file.
2. You may see your file at anytime during regular agency business hours.
3. If for any reason you disagree with action taken regarding your needs, you have the right to file a complaint, known as a "grievance", with this agency. This must be done in writing by contacting this agency within ten (10) days of the date given at the top of this form. If you need help with preparing or filing your grievance, call this agency. The agency will explain to you and give you a copy of the grievance procedure.
4. You have the right not to be discriminated against or "treated differently" because of your political affiliation, religion, race, color, sex, handicap, national origin, or age. If you think you have been discriminated against, you should discuss this with your service worker, or with the Director of this agency. If you are still not satisfied, you may write to the Title VI-504 Coordinator, Office of Aging, Peachtree Street, Atlanta, Ga. 30306

YOUR RESPONSIBILITIES

1. To give correct information to your worker.
2. To report any change affecting your need for services. This is very important.
To report changes, just give your worker a telephone call.
3. If you are awaiting services, you should tell the agency any changes in your situation affecting your need for services.

Acknowledgment of Recipient: I have read or had explained to me my rights and responsibilities related to the SSBG/Title III services.

Signature of Client

Date signed

Greene County Senior Center

Food Removal Waiver

I, _____ (client) am removing food from the Senior Center. I understand that I am removing food at my own risk. Food should be refrigerated as soon as possible or at least within 2 hours of removal from the Center. The food should be reheated to at least 165 degrees before consuming and discarded after 2 days. I understand that this is true every time I remove food from the Senior Center and will not hold the Greene County Senior Center or any of its affiliates liable for any illnesses or health issues related to food that I removed from the Senior Center.

Client Signature _____ Date _____

Witness _____ Date _____