Dear Rehabilitation Services & Stroke Day Program Participant:

Welcome! We are glad you have decided to join the Easter Seals Colorado Rehabilitation Services & Stroke Day Program. We are confident you will enjoy the therapeutic activities and achieve rewarding benefits. Please complete the forms in the attached packet, sign and submit them prior to entrance into the Rehabilitation Services & Stroke Day Program.

You will need to bring a lunch (which must be labeled with your name) unless you order one, personal items for the pool including towels, swim suit, water shoes, and any medications you may need. The program will provide you with a safe place to store your belongings during the day. However, please do not bring valuables, as the Rehabilitation Services & Stroke Day Program is not responsible for safeguarding your valuables. The Rehabilitation Services & Stroke Day Program hours are 9:00 am - 3:00 pm. Please feel free to arrive any time after 8:45 am and socialize, relax, and have some coffee until the therapeutic exercise starts at 9:30 am. Please make ride arrangements to be picked up between 2:45 and 3:15 at the Whitlock Recreation Center (1555 Dover St., Lakewood, CO 80215) or at 1755 Dover as appropriate. If you are riding Access-a-Ride, please ask for a “pick-up window” of 2:45-3:15 pm. If Access-a-Ride is unable to accommodate this time, select an earlier “pick-up window” such as 2:30-3:00 pm. It is imperative that all participants are picked up no later than 3:15 pm when the program closes.

After you begin attending the program, you will have a Occupational, Physical Therapy, and Speech Therapy (as appropriate) evaluation.

On the first day you attend the program you will complete a calendar indicating the days you plan to attend and make a payment for the entire month. During subsequent months, you will be required to submit your calendar and payment before the beginning of the month. We utilize your planning calendar to schedule staff for program days. Please be aware of our attendance and cancellation policy, as follows. If you are unable to attend on a scheduled day, you need to call the Rehabilitation Services & Stroke Day Program office by 8:30 am on that day. If you do not communicate your absence, you will not receive a make-up day. In place of your missed day you will receive a “make-up day”, rather than receiving credit on the next month’s bill. The “make-up day” needs to occur on a day other than your “regular attendance days of the week” and should occur within two weeks following the absence. There are no credits or refunds of fees paid.

Transportation to and from the Rehabilitation Services and Stroke Day Program, as well as related costs, are the responsibility of the participant. Many individuals arrive and depart from the program via Access-a-Ride and the participant is responsible for the arrangement of these rides as well as the cost. Participants are also responsible for securing “back-up” transportation should their scheduled ride fail to arrive. All participants must be picked up no later than 3:15 pm on any program day.

You have the right to designate your Advanced Directives in the event that you require advanced medical care or life support. Advanced Directives are written instructions about your wishes for medical treatment. They are used if you are unable to make your own health care decisions. It contains forms for a Living Will and a Medical Durable Power of Attorney. This information is available at http://www.cdphe.state.co.us/em/Operations/AdvanceDirectives/index.html. You may also call the Colorado Department of Public Health & Environment at 303-692-2980. If you choose to designate your Advanced Directives, if is necessary for
you to obtain your physician’s signature. If you wish the Rehabilitation Services & Stroke Day Program to follow these directives, it is necessary for us to have a copy on file.

Admittance into the Rehabilitation Services and Stroke Day Program is based on the participant’s level of functioning, interest in rehabilitation, and the staff’s ability to meet the participant’s needs. We are able to charge minimal fees for attendance because most therapy is provided in a group format, while keeping individual therapeutic goals in mind. We are able to provide limited one-to-one therapy during the day, but our staff-participant ratio requires that participants function with a minimum level of independence. Participants must be able to toilet, transfer, and dress themselves with stand-by assistance provided by a staff member in order to participate in the program. If more assistance is necessary, participants must bring an aide with them who can assist with these activities. Once a participant begins the Rehabilitation Services & Stroke Day Program, the staff will observe the individual and if it is deemed that we are unable to meet the participant’s needs, we will inform the caregiver and participant of this decision.

Caregivers of participants attending the Rehabilitation Services & Stroke Day Program are invited to attend the Caregiver Coffee held monthly. The dates will be announced in the monthly newsletter and calendar mailed to all participants. The Caregiver Coffee is a time for caregivers to share experiences, as well as gain new information and insight. The Caregiver Coffee meets at the Rehabilitation Services & Stroke Day Program facility.

We are excited and optimistic about your future success in the Rehabilitation Services and Stroke Day Program. Please contact me at any time with questions or suggestions.

Warm regards,

Karen Garber
Director
303-274-5415
kgarber@eastersealscolorado.org

Participant Letter
CLIENT INFORMATION

In accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, clients of Easter Seals Colorado are entitled to the greatest degree of privacy possible. Easter Seals Colorado will strive to ensure that client information is used only for the authorized purposes as agreed to by the client.

Name: ______________________________ Age/Birth date: ________________

Address: ______________________________ City___________________________

County: __________________________ State: _____ Zip: ________________

Home phone:____________________ Cell phone:___________________________

Email address: __________________________________________________________

Living Environment (home, apartment, facility):_____________________________

Household count _________ Education level:_______________________________

Referral Source: Name:_______________________________________________

Agency:________________________________________

Equipment Used: (w/c, walker, cane.)____________________________________

Support System (family, friends, caregiver): ______________________________

Emergency Contact: _____________________________________________________

Home phone: ________________ Cell phone: _________________________

Work phone: ________________ Email: ____________________________

Main goal of Client: ____________________________________________________

MEDICAL INFORMATION

Physicians Name: ____________________________ Phone: ____________________

Insurance __________________________ Carrier: ____________________________
Current Medications:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Illness/Disorder: ______________________________________________________

Date of illness/disorder onset: _______________________________________

Please indicate which of the following apply (describe where indicated):

___Allergies_____ ___Headaches/Migraines
___Asthma _________ ___Hearing Loss
___Arthritis/Tendonitis ___Hepatitis
___Artificial Joints___________ ___HIV/AIDS
___Back Injuries _____________ ___Insomnia
___Blood Clots_______________ ___Jaw/TMJ
___Blood Pressure (high/low) ___Broken ___Kidney Problems
Bones_______________________ ___Numbness____________________
___Bruises __________________ ___Osteoporosis
___Bursitis/Gout _____________ ___Pain________________________
___Cancer__________________ ___Stress/Tension
___Cardiac/Stroke___________ ___Surgeries___________________
___Circulation Problems     
___Diabetes                 
___Digestive Problems      
___Epilepsy/Seizures       
___Fatigue                 
___Fibromyalgia

List any allergies ___________________________________________________
Additional Medical Conditions (not listed above): __________________________

_______________________________________________________________________

Describe any Behavioral problems: ________________________________

_______________________________________________________________________

Additional information you want us to know about ________________

_______________________________________________________________________

_______________________________________________________________________
Easter Seals Colorado  
Stroke Day Program  
Consent Form

Client Name: ________________________________________________
Client Address: ______________________________________________
Legal Guardian: ______________________________________________
Emergency Phone Number: ______________________________________

Provider: Easter Seals Colorado

I, _____________________________, hereby give my permission that  
_____________________________, use any equipment Easter Seals Colorado has,  
or may obtain, with the following exceptions:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Please initial if you agree:

1.____ PICTURES. I authorize Easter Seals Colorado to film, photograph, or videotape me and use the same for news releases, newspapers, magazines, television, web sites or other media, and marketing of Easter Seals Colorado.

2.____ MEDICAL POWER OF ATTORNEY. (FOR EMERGENCY CARE ONLY) If I suffer an illness or medical emergency while in the care of Easter Seals staff and my emergency contact cannot be reached, this agreement shall constitute consent of myself to the provision of emergency medical care by an EMT, hospital, medical facility or physician and shall be determined by Easter Seals staff. It is the policy of Easter Seals Colorado to call 911 in an emergency.

3.____ TRANSPORTATION. (If someone other than the participant signs, I hereby give my permission for _________________________to be included in any outings and to travel in Easter Seals vehicles.

Signature: ___________________________
Relationship: _________________________
Date: ________________________________

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, clients of Easter Seals Colorado are entitled to the greatest degree of privacy possible. Easter Seals Colorado will strive to ensure that client information is used only for authorized purposes as agreed to by the client.
LEISURE ASSESSMENT

In accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, clients of Easter Seals Colorado are entitled to the greatest degree of privacy possible. Easter Seals Colorado will strive to ensure that client information is used only for authorized purposes as agreed to by the client.

Please complete the following information to your comfort level:

Name_______________________________ Date____________________________

Education Level______________________ Religion_________________________

Previous Occupation__________________ Retirement Date__________________

Marital Status________________________ Name of Spouse__________________

Children______________________________________________________________

Please check all activities that you enjoy:

MUSIC & ART

_____ Radio/Tapes
_____ Dancing
_____ Photography
_____ Museums
_____ Instruments
_____ Concerts
_____ Other__________

NATURE

_____ Gardening
_____ Bird Watching
_____ Fishing
_____ Camping/Hiking
_____ Other__________

CRAFTS

_____ Ceramics
_____ Painting/Drawing
_____ Woodwork
_____ Sewing/Knitting
_____ Other__________

GAMES

_____ Board Games
_____ Crossword Puzzles
_____ Cards
_____ Bingo
_____ Other__________

SPORTS

_____ Swimming
_____ Golf
_____ Bowling
_____ Walking
_____ Tennis
_____ Weight Lifting
_____ Other__________

COMPUTER SKILLS

_____ Typing
_____ Internet
_____ E-mail
_____ Programs
_____ Other__________

Describe Yourself To A Stranger: __________________________________________
_____________________________________________________________________________________

3.13
Problem Areas you would like to work on: _________________________________
_______________________________________________________________________
________________________________________________________________________
What is your primary reason for attending the Stroke Day Program:___________
_______________________________________________________________________
_______________________________________________________________________
Describe your daily routine at home:_______________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Comments: _____________________________________________________________
_______________________________________________________________________
EASTER SEALS COLORADO
Rehabilitation Services and Stroke Day Program
Consent for Release of Information

Effective Date: From:____________ To:____________ (usually effective for 1 year)

Client name:__________________________________ Date of Birth_____________

Address: ___________________________________________________________________

City: ______________________________ State: ________________ Zip___________

Primary Physician or Health Care Provider (HCP): ______________________________

Address: ___________________________________________________________________

I,________________________________ (participant/guardian/POA) give my permission for the
following documents to be released:

_____ Medical Records - Dates: ______________________________

_____ Other (describe) _______________________________ Dates: ______________

The documents above are approved to be sent from: (Check one or both)

☐ Health Care Provider to Easter Seals Colorado
☐ Easter Seals Colorado to Health Care Provider

Easter Seals Colorado Rehabilitation Services & stroke Day Program: c/o Lakewood
Nazarene Church, 1755 Dover St., Lakewood, CO 80215

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, clients of
Easter Seals Colorado are entitled to the greatest degree of privacy possible. Easter Seals Colorado will
strive ensure that participant information is used only for authorized purposes as agreed to by the
participant.

Signature of Participant__________________________________ Date___________

Signature of Guardian (POA)______________________________ Date___________
Stroke Day Program

Pet Assisted Therapy

Easter Seals has partnered with the Delta Society and Denver Pet Partners to provide Pet Assisted Activity and Therapy for our program. We want to make sure you know that for the safety of the participants, the dogs and their trainers have gone through a rigorous screening process and have been thoroughly trained and tested to participate in this program. The dogs and their trainers will participate in a group session with our clients in the morning and then work with our therapists and clients on an individual basis throughout the morning. If you would like to be involved with this type of therapy please initial below.

____ I would like to be included in the Pet Assisted Therapy Program at Easter Seals Stroke Day Program.

____ I DO NOT want to participate in the Pet Assisted Therapy Program at Easter Seals Stroke Day Program

Please indicate if you have any allergies or fear of dogs:

____ I am allergic to dogs

____ I am fearful of dogs

________________________________________   __________________________
Participant Signature   Guardian signature
NOTICE: THIS IS A LEGALLY BINDING AGREEMENT, PLEASE READ CAREFULLY. By signing this agreement, you give up your right to recover for any injury to you or your property, however caused, arising out of your participation in the Stroke Day Program.

I ACKNOWLEDGE AND AGREE that the Stroke Day Program, located at 1755 Dover Street, Lakewood, Colorado, and the Whitlock Recreation Center warm water pool, located at 1555 Dover Street, Lakewood, Colorado has inherent risks. I have full knowledge of these risks both foreseeable and unpredictable, associated with the participation in this program, and may include actions or inactions of Easter Seals Colorado, its agents and volunteers, and those of other participants. I am freely choosing to assume those risks by participating in the program.

In consideration for my participation in the Stroke Day Program and related facilities owned and or operated by Easter Seals Colorado, by signing below, I agree to release, indemnify and hold harmless on behalf of myself, my heirs, representatives, executors and administrators assigns for any and all claims, including claims for negligence resulting from, or arising out of any personal injury including death, property damage, or accident of any kind, arising out of or in any way connected to my use or participation in this Stroke Day Program. I also agree to indemnify Easter Seals Colorado, its employees, agents and volunteers for any injury or claim by third parties against them resulting in any way from actions on my part, whether such actions are intentional, reckless or negligent.

I agree that this Waiver and Release of claims shall be given the fullest force allowable under Colorado law that, should any part of it be found to be unenforceable, the remainder of the agreement shall be severed and remain in full force and effect. Further, I grant Easter Seals Colorado, and all sponsoring businesses and organizations and their agents permission to use any photographs, motion pictures, recording or any other record for any legitimate promotion or purpose.

Clients of Easter Seals Colorado are entitled to the greatest degree of privacy possible. Easter Seals Colorado will strive to ensure that client information is used only for authorized purposes as agreed to by the client.

I HAVE READ AND UNDERSTAND THIS RELEASE AND AGREE TO ITS TERMS.

_____________________________  __________________________ _____________
Please Print Name    Please Sign Name    Date

_____________________________Guardian signature (if applicable)
Easter Seals Colorado
Rehabilitation Services and Stroke Day Program
Contract for Services

This is a contract for rehabilitation services for _________________________________
(Participant).

This contract is between Easter Seals Colorado Rehabilitation Services & Stroke Day Program (ESC) and
__________________________________ (Responsible Party or POA, if designated).

This contract begins on the first day of attendance in the program and continuing month-to-month until
written notice by ESC or participant and/or responsible party.

Your Rights and Responsibilities:

- You have a right to be free of discrimination and to be treated with consideration and respect.
- You have the rights stated within the American’s With Disabilities Act (ADA).
- You have the right to make choices regarding your day program and activities.
- You have the right to a confidential record.
- You have the right to give input which may influence the services received and/or policies of the
  agency.
- You are responsible for following directions of the therapeutic staff of the Rehabilitation Services &
  Stroke Day Program which impact your personal safety as you move about in the program. Failure to
  follow safety guidelines could impact your ability to continue in the program.

Responsibilities of the Rehabilitation Services & Stroke Day Program:

- The staff of the Rehabilitation Services & Stroke Day Program are responsible to treat you with respect
  and consideration and take into account your individual wishes.
- The staff of the Rehabilitation Services & Stroke Day Program are responsible for evaluating your
  functional capabilities and providing feedback on the program’s ability to meet your individual needs.
- The Rehabilitation Services & Stroke Day Program staff, following a therapeutic evaluation, will inform
  you of their recommended therapeutic plan and guidelines for you to prevent injury and function safely
  within the program exercises and activities.
- The Rehabilitation Services & Stroke Day Program will maintain records of your therapeutic evaluation,
  your attendance and your personal/medical data in a confidential manner.
- The Rehabilitation Services & Stroke Day Program will be open between the hours of 9:00 and 3:00 pm
  and the staff will remain with the participants until all participants are picked up by their transportation
  provider.

Participant, Responsible Party, and POA (if designated) agree to the following conditions:

- In order to maintain program eligibility, a minimum attendance commitment of 1 day per week is
  required.
- Prepayment of one month’s fee received no later than 1st day of month or first day of attendance.
- A 10% late payment penalty will be assessed for payments received after the 1st of the month.
- Program participation will not be permitted until all fees are paid.
- If participant misses any committed time and notifies the program by 8:30 am on the date
  of the absence, there is an opportunity to make up the day(s) within the two weeks
immediately following the absence. Fees for make-up days are not credited to the participant’s account. The participant must schedule a make-up day which will be in addition to the regular scheduled days of attendance. If the participant attends twice per week, he/she will attend three times per week when the make-up day is used.

-No cash refunds will be provided unless program services are terminated by ESC.

Stroke program director will determine excused absences; which may include major medical with physician documentation or death in family or weather-related closures.

Unexpected absences require notification to the program director by 8:30 am on the day of the absence.

Participants will need to provide two weeks notice of any vacation time. No credits are available for unscheduled vacation time.

Participant and/or responsible party can change their participation days with two weeks notice. (Scheduling of your use of the program permits more effective allocation of staff and the specialized services required to meet your needs.)

-If participant and/or responsible party does not provide written or verbal notice of absence to the stroke program director or does not come to the program for two weeks without notice, that participant vacates their place in the program.

-Consistent absences from program by participant will be reviewed with participant and responsible party by the Program Director to determine if participant continues to express interest in the program. If it appears that the individual has lost interest in the program, discontinuation of services will be recommended.

-Should a former participant who has their place in the program through non-participation or through verbal/written notice wish to attend the program, they must complete a new application or update their prior application. This does not guarantee program availability.

-Checks that do not clear the bank are subject to the bank’s non-sufficient fees and a service fee of $25. All non-sufficient funds are subject to collection. A participant and/or responsible party who has a non-sufficient fund payment will be required to pay in cash or money orders for all future visits.

-Admittance into the Rehabilitation Services and Stroke Day Program is based on the participant’s level of functioning, interest in rehabilitation, and the staff’s ability to meet the participant’s needs. We are able to charge minimal fees for attendance because most therapy is provided in a group format, while addressing individual therapeutic goals. We are able to provide limited one-to-one therapy during the day, but our staff-participant ratio requires that participants function with a minimum level of independence. Once a participant begins the Rehabilitation Services & Stroke Day Program, the staff will observe the individual and if it is deemed that we are unable to meet the participant’s needs, we will inform the caregiver and participant of this decision.

Medication Administration Policy:

-All medications (prescription and non-prescription) must be fully labeled by the pharmacy/manufacturer with participant’s name, date prescribed, and administration directions. Additionally, all medication (prescription and nonprescription) must be listed on the Medication Orders form, signed by the participant’s physician, which is provided to the Rehabilitation Services & Stroke Day Program by the participant along with the labeled medications identified. Upon arrival, all medication must be given to the program staff to be placed in locked storage until the time of administration. The Rehabilitation Services & Stroke Day Program staff are responsible for maintaining records of your medication administration.

-By signing below I indicate that I have received a copy of the

  • “Participant Letter”
  • “What to Bring” list
• Written Advanced Directives information
• Copy of Participant Contract
• Grievance Policy
• Medication Administration Policy
• Rehabilitation Services & Stroke Day Program informational brochure

-By signing below I indicate that I have
  • Received an orientation of the facility, program policies & procedures
  • Notified the Rehabilitation Services & Stroke Day Program whether I have a Power of Attorney and, if so, my Power of Attorney has signed this document
  • Notified the Rehabilitation Services & Stroke Day Program whether I have designated Advanced Directives and, if so, I have provided a copy of this document to the program

The signature below indicates an attendance commitment for the month of: _________________, 201__ and until further notice.

Please initial next to requested weekly attendance

______ 1 day per week
______ 2 days per week
______ 3 days per week
______ 4 days per week
______ 5 days per week

Signature: __________________________________ Date ______

By: __________________________________ Date ______

Print name

Responsible Party or POA (if designated) Signature:

________________________________________ Date ______

Print name and address of person responsible for payment:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Phone: __________________________________________

Email: __________________________________________

Easter Seals Colorado Rehabilitation Services & Stroke Day Program

Staff Signature: __________________________________________

Title: __________________________________________

Date: __________________________________________
To: Participants in the Rehabilitation Services & Stroke Day Program,

We offer financial assistance to those who qualify based on need. If you believe you may qualify and would like to apply to receive a scholarship for the Rehabilitation Services & Stroke Day Program please complete the following paperwork in addition to the initial forms. Easter Seals Colorado will then review the forms and let you know as soon as possible if you qualify. It is necessary for you to enclose your most recent state tax return with your financial assistance application.

We will continue to re-evaluate financial needs and scholarships each quarter, as the funds and space are available. There is never a guarantee of scholarship funds. We hope to meet the needs of our participants requiring special consideration with the small amount of funding with which we are approved.

Thank you for your interest in the Rehabilitation Services & Stroke Day Program and I look forward to working with you.

Sincerely,

Karen Garber
Director
303-274-5415
Easter Seals Colorado
Rehabilitation Services & Stroke Day Program

Financial Assistance Application

All application information is confidential. A participant may qualify for Easter Seals Colorado financial assistance for the stroke center based on the level of family income versus expenses. Designated Easter Seals Colorado personnel, upon review of your application, make a determination of assistance. If you qualify, Easter Seals Colorado will provide financial assistance based on the scholarship funds we have available. We hope to meet the needs of our participants requiring special consideration with the small amount of funding with which we are provided. Please fill out the following application, enclose your most recent state tax return, and return it to the Easter Seals Colorado Rehabilitation Services & Stroke Day Program director at c/c Lakewood Nazarene Church, 1755 Dover St., Lakewood, CO 80215.

First Name _________________________ Last ___________________________
Address ____________________________ City _________ State ____ Zip _____
Phone ___________________________ Alt. Phone __________________________
Occupation _______________ Parent/Guardian/Spouse ______________________
Total number members of household: ______________
Total annual household income: $______________ (Use figures from your 1040 tax returns and attach copy to this form)

Medical expenses NOT reimbursed by insurance last calendar year $________
Dental Expenses NOT reimbursed by insurance last calendar year $________

Please circle all that are applicable:
Food Stamps   SSI     Amount: _______________________________
Medicaid     Medicare   SSDI  Amount: _______________________________
Pension  Amount: _______________________________
Other Support  Amount: _________________________
____________________________________________________ _____________
Participant Signature       Date
____________________________________________________  _____________
Caregiver and/or POA
____________________________________________________ Date

In accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, clients of Easter Seals Colorado are entitled to the greatest degree of privacy possible. Easter Seals Colorado will strive to ensure that client information is used only for authorized purposes as agreed to by the client.

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
For Office Use Only:  
Authorized by: ________________________________ Date: ______________  
Easter Seals Colorado  
Amount granted _____________________________________________ per day
ADVANCED DIRECTIVE INFORMATION

FEDERAL LAW REQUIRES THAT YOU MUST BE GIVEN information on advance directives at the time you are admitted by any hospital, nursing home, HMO, hospice, home health care, or personal care program that receives federal funds (Medicare/Medicaid). You must also be given written information on policies of that facility or provider concerning advance directives.

Medical advance directives are legal documents that tell medical professionals and others about your desires concerning your medical treatment for use in the event you can no longer speak for yourself. The term “medical advance directive” most commonly refers to a living will, but the term may also include medical durable powers of attorney, cardiopulmonary resuscitation (CPR) directives, Do Not Resuscitate (DNR) orders, Medical Orders for Scope of Treatment (MOST), and other directives concerning your care and disposition in the event your medical condition is terminal, and at or after the time of your death.

MEDICAL DURABLE POWER OF ATTORNEY

- In Colorado, no one is automatically authorized to make healthcare decisions for another adult.

- The Medical Durable Power of Attorney (also called the “Power of Attorney for Healthcare”) is a document you sign to appoint someone to make your healthcare decisions for you. The person you name is called your healthcare agent.

- In most cases, your agent only makes decisions for you when you cannot. This may be temporary, while you recover from an accident or injury, or long term, if you are permanently incapacitated.

- Your agent can get copies of your medical records, consult with your doctors and other healthcare providers, and make all decisions necessary for your care.

- Your agent is supposed to act according to your wishes and values, so it’s important to talk to them about your life values, your goals, and your preferences for treatment. Ideally, the agent is someone who knows you very well. He or she must be able to devote the time and energy to handling your health care needs.

- A Medical Durable Power of Attorney (MDPOA) is not the same as a general Power of Attorney (POA). The MDPOA agent is only authorized to make healthcare decisions. A general POA covers legal and financial affairs. The authority of both types of agent ends at your death.

LIVING WILL

- In Colorado, the Living Will is called the “Declaration as to Medical or Surgical Treatment.”

- It tells your doctor what to do about artificial life support measures if you have a terminal illness and unable to speak for yourself, or you are in a "persistent vegetative state" (a state of permanent unconsciousness involving massive brain damage but not "brain death.")

- In Colorado, your Living Will does not go into effect until 48 hours after two doctors agree in writing that you have a terminal condition and are unable to speak for yourself or you are in a persistent vegetative state.

- In these circumstances, your Living Will directs your doctors to continue or discontinue, as you specified in the document, life-sustaining procedures, artificial nutrition, and artificial hydration.

- In the Living Will document, you can list people you want to be kept informed of your condition and the doctors’ certification of terminal illness or persistent vegetative state.
• You may also detail other medical instructions, but these instructions will only be followed when your living will goes into effect (that is, after the doctors' certification).

• You do not need an attorney or a doctor to complete a Living Will, but you do need two witnesses. The witnesses cannot be your healthcare providers, an employee of your healthcare provider, your creditors, or anyone likely to inherit property from you.

• A notary’s signature and seal is a good idea but not required.

• A Living Will is not the same as a regular will (“Last Will and Testament”) or a Living Trust, which refer to possessions and property. A Living Will only provides instructions on medical treatment, not the distribution or disposal of your property.

**CPR DIRECTIVE**

• A CPR (cardiopulmonary resuscitation) directive allows you to refuse in advance any attempt to resuscitate you by chest compressions, medications, defibrillation (electric shock), or intubation (artificial breathing machine) if your heart or breathing malfunctions or stops.

• CPR directives are almost always used by people who are severely or terminally ill or elderly. For them, the trauma involved in CPR is likely to do more harm than good, but emergency personnel are required to perform CPR unless a directive tells them not to.

• A CPR directive is not the same as a DNR order. A DNR order is a doctor’s order made for severely ill patients in healthcare facilities, including nursing homes. The DNR does not require the patient’s consent, and it expires when the patient leaves the facility.

• The Colorado CPR directive must be signed by both the individual (or the individual’s MDPOA agent or “proxy”—see below) and his/her physician. Other CPR directive forms may not require a physician’s signature.

• A CPR directive form does NOT have to be “original” nor do the signatures have to be “original.” Photocopies, scans, and faxes are just as valid as the original.

• CPR directives must be immediately visible to emergency personnel. For more active folks with CPR directives, a wallet card or special CPR directive bracelet or necklace can be obtained.

• Unless you have a signed CPR or DNR directive, the law in Colorado, the standards of medical practice, will require medical professionals to make all reasonable efforts to restart your heart in the event it stops.

• Easter Seals Colorado policy regarding CPR or DNR directives will comply with the law in Colorado and standard medical practice and all reasonable efforts to restart your heart in the event it stops, and 911 emergency will be initiated.

• A CPR Directive is not exactly the same as a DNR (Do Not Resuscitate) order, although many people refer to the CPR directive as a DNR. A DNR order is written in your medical chart by your doctor while you are being cared for in a healthcare facility, such as a hospital or nursing home. The doctor will likely discuss this order with you or your surrogate decision maker, but does not have to. DNR orders are written when your doctor believes that resuscitation would not work or might cause more harm than good. (Fewer than 1 in 10 elderly, frail or seriously ill persons will survive resuscitation attempt; if they do survive, they might end up with traumatic injuries or brain damage). If you recover well enough to leave the facility, the DNR order expires at your discharge.
MEDICAL PROXY FOR DECISION MAKING

- In Colorado, no one is given automatic authority to make decisions for another adult, and healthcare providers cannot simply make decisions for patients except in an emergency.

- If you have not appointed a healthcare agent, and if you are unable to make or express decisions for yourself, a “proxy” is needed.

- The physician has the responsibility to gather together all the people who have an interest in your well-being, for instance your spouse or partner, parents, adult children, grandchildren, brothers or sisters, close friends, or even professional advisors such as clergy, attorneys or financial managers.

- The group of "interested parties" must agree by consensus which one of them will serve as your "proxy" decision maker.

- Like your agent, your proxy should act according to your wishes and values, so the proxy should be the one who knows your medical treatment wishes the best.

- Proxies selected in this way cannot refuse artificial nutrition and hydration for you, unless two doctors agree that such treatment would not help you get well but would only prolong dying.

- If the group can’t agree on who the proxy should be, then guardianship needs to be pursued through the courts.

Easter Seals Colorado
Advance Directives

I, _______________________________________, have received written documentation regarding advance directives according to state law.

Signature:____________________________________Date:_________________
(Client)

Signature:____________________________________Date:________________
(responsible party other than the client)
WHAT TO BRING WITH YOU WHEN YOU ATTEND THE REHABILITATION SERVICES AND STROKE DAY PROGRAM:

1. Bring your lunch with your name on it unless you order one. If your food needs to be reheated, microwaves are available. Sandwiches are the most practical lunch item. We have a refrigerator available to store your lunch if needed.

2. If you bring medications with you, a doctor’s order must accompany them and medications can only be brought in the original, marked pharmaceutical container. Medications will be locked when participants arrive with them and a staff member who is certified in medication administration will administer them. Participants are not allowed to keep medication on their person while at the program. Medications cannot be stored at the program facility.

3. Bring a swim suit. Men and women who need assistance dressing before and after swimming should wear their suit under their clothes as they arrive at the program. Women who need assistance dressing must wear a two-piece suit (Tankini - see below) which has the same amount of coverage as a one-piece, but it is easier for the participant to learn how to take it on and off and to toilet themselves. Depends can be worn underneath swimsuits and can be removed prior to entering the pool.

4. Bring a towel.

5. Bring water shoes. Water shoes can be purchased at Sports Authority all year round and at Target and Walmart during warmer months. Water shoes help the participant maintain traction while walking in the locker-room as well as inside the pool.

6. Wear a coat that is appropriate for the season. We walk from our church location to the pool next door most days. If there is inclement weather, we will take the bus. Warm winter coats are a necessity! Please error on the side of dressing too warmly.
7. Bring your attendance calendar marked with the days you plan to attend as well as a check for the corresponding amount. The fee is $70/day and payment is required for the full month in advance. Participants new to the program may pay on a daily basis for two weeks to ensure that they feel comfortable with the program and feel that it meets their needs. In this case payment is required in the morning prior to each day of attendance. A $50 evaluation fee is also required on the first day of attendance. The Physical, Occupational and Speech Therapist (as appropriate) will evaluate each participant and develop an individualized therapy plan within the first few weeks of attendance. No refunds are provided.

8. Do not bring cash, credit cards, checks, jewelry, or other valuables to the Rehabilitation Services & Stroke Day Program facility. The program will provide a safe place for you to keep your lunch, swim attire, and clothing that you bring to the program. We cannot be responsible for securing your valuables.
Easter Seals Colorado
Rehabilitation Services & Stroke Day Program

Participant and Caregiver (and/or POA) Orientation

Participant Name __________________________________________

**Participant:**

___ Participant has been introduced to the staff and fellow participants
___ Participant was oriented to monthly calendar of events & schedule
___ Participant has reviewed the “What to Bring” Summary
___ Participant has review the Participant Letter
___ Participant has received information about Advanced Directives

**Caregiver (and/or POA) has been oriented to the following:**

___ Monthly calendar of events & schedule
___ “What to Bring” Summary
___ Participant Letter
___ Caregiver (and/or POA) has received information about Advanced Directives

Caregiver (and/or POA) has toured the facility with a staff member and has seen the following:

___ Parking
___ Accessible Entrance
___ Program Offices
___ Kitchen
___ Classroom
___ Gymnasium
___ Therapy Room
___ Accessible Bathrooms
___ Participant Personal Belongings Storage
___ Refrigerator for Participant Lunch Storage
___ Medication Locked Storage

Staff Signature ____________________________________________
Date ____________________________

Caregiver (and/or POA) Orientation  
Keep in Participant File under Participant Information

Easter Seals Colorado  
Rehabilitation Services & Stroke Day Program

EMERGENCY SHEET

Today’s Date: ____________________

Name: ___________________________ Birth date: ________________

Address: __________________________ City _______________ State __________

Zip: __________ Phone (h): _______________ Phone (c): _______________

POA: Y/N Name: ___________________________ DNR On File: Y/N

Living Will On File: Y/N Anatomical Gift: Y/N

Medical Condition/ Disability: ____________________________

Secondary Conditions: ____________________________

ALLERGIES: ____________________________

EMERGENCY CONTACTS:
1. Name: ___________________________ Relationship: _______________ POA Y/N

Address: ___________________________ City: _______________ State: ______

Zip: __________ Phone (h): _______________ Phone (c): _______________

2. Name: ___________________________ Relationship: _______________ POA Y/N

Address: ___________________________ City: _______________ State: ______

Zip: __________ Phone (h): _______________ Phone (c): _______________

3. Name: ___________________________ Relationship: _______________ POA Y/N

Address: ___________________________ City: _______________ State: ______

Zip: __________ Phone (h): _______________ Phone (c): _______________

MEDICAL INFORMATION:

Physician’s Name: ____________________________

Address: ___________________________ City: _______________ State: ______

Zip: __________ Phone (O): _______________ Phone (c): _______________