



*ENROLLMENT APPLICATION*

25 Brayton Avenue  
Cranston, Rhode Island 02920  
(401) 946-9220 Fax (401) 946-3850

Ellen Grizzetti – President & CEO

## **WHAT IS HOPE ALZHEIMER'S CENTER?**

Hope Alzheimer's Center is a comfortable, safe and homelike day center staffed by caring and skilled individuals who provide comprehensive health, personal care, social and therapeutic services.

## **WHAT IS THE MISSION OF THE HOPE ALZHEIMER'S CENTER?**

To be a leader in fulfilling the unique needs of the individual with dementia and supporting their caregivers, while optimizing each person's independence and dignity.

We will accomplish this by...

Providing quality and compassionate services in a safe and caring environment

Focusing on the individual's abilities and strengths while being sensitive to limitations

Providing therapeutic activities that enhance self-esteem

Providing a socially and medially supervised environment

Encouraging independence and success

Providing education, emotional support and personal counseling

Providing educational lectures and workshops for the caregiver to enhance a therapeutic environment at home

Recruiting and retaining a quality staff

Sharing our expertise with health care professionals and the community

## **WHO IS ELIGIBLE TO ATTEND?**

- Individuals who have a medically confirmed memory loss resulting from Alzheimer's disease or related dementia
- Individuals who would benefit from structured, meaningful activities which encourage social stimulation and preserve self-esteem
- Individuals who have a need for ongoing health monitoring, supervision with nutrition and medication, or assistance with personal care
- The Center will not discriminate in serving any person on any legally recognized basis, including but not limited to race, color, religion, sex, marital status, pregnancy, physical or mental disability, age national origin, sexual orientation, ancestry or veteran status.

## **HOURS OF OPERATION AND NONDISCRIMINATION POLICY**

- Hope Alzheimer's Center is open Monday through Friday from 8:00 a.m. – 4:00 p.m.
- The Hope Center operates in accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

## **HOW TO ENROLL IN THE HOPE ALZHEIMER'S CENTER PROGRAM**

- If you have questions or concerns or to arrange a tour, feel free to contact Hope Alzheimer's Center at 946-9220 and ask to speak with a case manager.
- Return completed forms to:  
Hope Alzheimer's Center  
25 Brayton Ave.  
Cranston, RI 02920

## SERVICES PROVIDED BY HOPE ALZHEIMER'S CENTER

### Program Activities:

A full range of daily social and therapeutic activities includes, but is not limited to the following:

- |                             |                             |                                |
|-----------------------------|-----------------------------|--------------------------------|
| *Watercolor program         | *Dance & movement therapy   | *Exercise and yoga             |
| *Current events             | *Horticultural therapy      | *Pet therapy                   |
| *Reminiscence               | *Cognitive Fitness          | *Mental stimulation activities |
| *Arts & crafts              | *Chair tap dancing          | *Arts & crafts                 |
| *Pottery program            | *Intergenerational programs | *Cooking                       |
| *Woodworking                | *Clay sculpting             | *Men's club                    |
| *Participants council       | *Poetry club                | *Entertainment                 |
| *Community service projects | *Music programs             |                                |

### Nutrition:

- Two meals and a snack provided (Hope participates in the CACFP Nutrition Program which helps us to provide balanced meals)
- Cueing and feeding assistance as needed

### Personal Care:

- In- house hairdressing services, including wash, cut, styling, perms, coloring, etc.
- Toileting assistance
- Nail care
- Showers can be provided on an emergency basis by certified nursing assistants

### Health Care:

#### **Skilled nursing services provided by registered nurses**

- Monthly health assessments; weight, BP, respiration and pulse
- Multidisciplinary care planning
- Medical follow-up and care coordination with physicians
- Nutritional supervision and management of special diets
- PT, OT and Speech therapy services provided on site in partnership with Saint Elizabeth Homecare Services

#### **Care may also include:**

- Dispensing of medication
- Dressing changes
- Injections
- Lab specimen collection
- Podiatry services provided by a visiting podiatrist
- Occupational, speech and physical therapy (arranged on a contractual basis)
- Health assessments
- Care planning assistance and family support

### Social Services/Care Management

- Client assessment
- Care coordination
  - In home service
  - Respite care
  - Hospice care
- Support groups
- Transportation services- may be arranged, on specially equipped vans on a space-available basis
- Guidance in determining eligibility for and in accessing financial assistance programs
- Assistance with long term care planning
- Educational programs for caregivers

**Application for Enrollment**  
**Hope Alzheimer's Center, 25 Brayton Avenue, Cranston, RI 02920**  
**401-946-9220 401-946-3850 Fax**

*(To Be Completed by Caregiver)*

**Applicant's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Medicare:** \_\_\_\_\_ **Medicaid:** \_\_\_\_\_

**Other Health Insurance:** \_\_\_\_\_ **Number:** \_\_\_\_\_

**Medical History:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Caregiver's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Primary Care Physician:**  
**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Specialists or additional physician contacts:**  
**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Does potential participant require a special diet?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**  
**If "Yes" please explain:** \_\_\_\_\_  
\_\_\_\_\_

**Does potential participant take medication on a daily basis?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**  
**If "Yes" please list:** \_\_\_\_\_  
\_\_\_\_\_

**Is potential participant incontinent of bladder or bowel?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**  
**If "Yes" please explain:** \_\_\_\_\_  
\_\_\_\_\_

**Does potential participant require assistance with ambulating?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**  
**If "Yes" please explain: Walker? Wheelchair? Cane?** \_\_\_\_\_  
\_\_\_\_\_

**Application for Enrollment (continued)**  
**Hope Alzheimer's Center, 25 Brayton Avenue, Cranston, RI 02920**  
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How many days of attendance are requested? \_\_\_\_\_  
 Which days are preferred? \_\_\_\_\_  
 Is transportation needed? \_\_\_\_\_

Please list any concerns or comments regarding applicant's physical health and/or emotional well-being:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Hope Alzheimer's Center Daily Fee **\$99.00**

Hope Alzheimer's Center ½ day fee **\$79.00**

\*A half day is defined at four (4) hours of care, and is limited to either **9 a.m. to 1 p.m. or 12 p.m. to 4 p.m.**

**\*Case Managers will work with family caregivers to secure State subsidies for those who are eligible**

Please find the Rhode Island Office of Healthy Aging 2026 Guidelines for the Cost-Share Program

1. Income of <b>\$19,950</b> (Single); <b>\$27,050</b> (Couple) - <b>\$7.00/day</b>
2. Income of <b>\$31,920</b> (Single); <b>\$43,280</b> (Couple) - <b>\$15.00/day</b>
3. Income of <b>\$39,900</b> (Single); <b>\$54,100</b> (Couple) - <b>\$15.00/day</b>

If you would like us to help determine your potential eligibility for subsidy programs please list the financial information of the **participant and spouse** combined:

<b>Income</b>	<b>Annual</b>
Social Security	\$ _____
Rental Property	\$ _____
Interest/Dividends	\$ _____
All Pensions	\$ _____
<b>Total</b>	\$ _____

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Legal Guardian/Power of Attorney Signature

\_\_\_\_\_  
 Date

Hope Alzheimer's Center  
Social History

Client Name: \_\_\_\_\_ Likes to be called: \_\_\_\_\_

Gender: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Place of Birth \_\_\_\_\_

Ethnic Background: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Secondary Language: \_\_\_\_\_

Religion: \_\_\_\_\_ Holidays Observed: \_\_\_\_\_

Diagnosis (es): \_\_\_\_\_

Diet Restriction/Intolerances: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_ Years Married: \_\_\_\_\_

Lives with: \_\_\_\_\_

Number of siblings: \_\_\_\_\_ Names most often remembered: \_\_\_\_\_

Number of children: \_\_\_\_\_ Names most often remembered: \_\_\_\_\_

Number of grandchildren: \_\_\_\_\_ Names most often remembered: \_\_\_\_\_

Educational history: \_\_\_\_\_

Occupational history: \_\_\_\_\_

Military history: \_\_\_\_\_

Interests: PLEASE CHECK APPROPRIATE LINES

Music: \_\_\_\_\_ Singing: \_\_\_\_\_ Dancing: \_\_\_\_\_ Movement Therapy: \_\_\_\_\_ Sports: \_\_\_\_\_

Painting: \_\_\_\_\_ Drawing: \_\_\_\_\_ Crafts: \_\_\_\_\_ Baking: \_\_\_\_\_ Spiritual Activities: \_\_\_\_\_

Exercise: \_\_\_\_\_ Walks \_\_\_\_\_ Gardening: \_\_\_\_\_ Reading: \_\_\_\_\_ Pet Therapy: \_\_\_\_\_

Checkers: \_\_\_\_\_ Chess: \_\_\_\_\_ Bingo: \_\_\_\_\_ Cards/What games?: \_\_\_\_\_ Reminiscence: \_\_\_\_\_

Additional Interests & Hobbies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Form**

**(must be completed by the participant's primary physician only)**

**Patient's Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Past & Present Diagnosis** (Please check or list as appropriate)

**Dementia diagnosis:**  Alzheimer's  Vascular  Mixed  Other \_\_\_\_\_  
 CAD  CHF  CVD  HTN  AFIB  PVD  DM  
 Thyroid disorder  Depression  Cancer \_\_\_\_\_  
Other: \_\_\_\_\_

**\*Please check the following medications that may be given on a PRN basis:**

Tylenol  Ibuprofen  Maalox  Tums

**Food or Medication Allergies or intolerances?**  Yes  No

**Special dietary requirements** \_\_\_\_\_

**Summary of Last Physical Exam/Vitals** **Date of Last Exam:** \_\_\_\_\_

**Blood Pressure** \_\_\_\_\_ **AP** \_\_\_\_\_ **Resp.** \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**Functional Status**

Does the patient ambulate independently?  Yes  No

If not, nature of assistance required:

Other limitations on activities \_\_\_\_\_

**Physical, Occupational, Speech Therapy**

There is no contraindication for my patient to receive  **Physical**,  **Occupational** or  **Speech** therapy by licensed therapists, providing group or individual treatment at the Hope Alzheimer Center. I consent to the receipt of these services.  Yes  No

**Current Medications and Dosage:** \_\_\_\_\_

**Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\*Family wishes may supersede Physician's Choice

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**MEDICAL RECORDS RELEASE**

I hereby request that any medical/mental health data pertinent to

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Be released to the Hope Alzheimer's Center. Also, medical data pertinent to his/her well being may be released in an emergency situation at the discretion of the Hope Alzheimer's Center staff. The Hope Alzheimer's Center also has the right to release any pertinent medical data to the Department of Veterans Affairs.

**APPLICANT'S SIGNATURE:** \_\_\_\_\_

**Or**

**LEGAL GUARDIAN/POWER OF ATTORNEY:** \_\_\_\_\_

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_

**Or**

I have read and understand the Medical Records Release and choose not to sign it. I further understand that my choice not to sign may result in the discontinuation of enrollment.

**LEGAL GUARDIAN/POWER OF ATTORNEY:** \_\_\_\_\_

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_