



Information Packet Day Treatment Program

Dear Client:

Welcome to Bering Omega Community Services – Day Treatment Program. The purpose of our program is to provide services to recipients residing in the community, dealing with HIV, and to prevent premature or unnecessarily prolonged placement in institutions. Services are designed to address the physical, medical, mental, and social needs of the clients through the provision of services which improve or maintain a person's level of functioning. Services include nursing care, physical therapy referral, nutritional counseling, meals and snacks, field trips, contests and games, educational speakers, and other activities to make for a rewarding experience.

Our mission is to improve the quality of life for those with critical needs by providing physical, emotional, and spiritual assistance to the patients who receive our care. Part of the goal of the Day Treatment Program is to create a safe and pleasant environment in which you can receive care while participating in activities. Your privacy will be protected.

Bering Omega Community Services – Day Treatment Program
1429 Hawthorne Street
Houston, Texas 77006
Phone: 713-341-3750
Fax: 713-520-7854

Becoming a Client

Step 1: CPCDMS Registration Information

The following will explain the steps to become a patient at Bering Omega Community Services – Day Treatment Program and other information you will need to know.

If you live in the following counties, you must register at a CPCDMS registration agency prior to your intake at the Care Center. These counties are: **Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.** See below for information on CPCDMS registration sites.

In order to comply with our funding sources, our clients must register with the new CPCDMS computer system. This system will allow you to show your **proof of income** and **proof of residency** once per year at a registration site, and then all the associated agencies can access this system. You will only have to show these documents to one agency, and will not have to carry them to each agency as you have done in the past. If you are not registered, we will be unable to see you.

CPCDMS registration sites and contacts:

AIDS Foundation Houston, Inc.	Gary Grier	(713) 623-6796
Baylor College of Medicine	Kristin Close	(832) 822-1366
City of Houston	Cathy Wiley	(713) 794-2980
Family Service Center	Veronica Garza	(713) 867-7747
Fort Bend Family Health Center	Sylvia Teeple	(281) 342-0529 x138
Harris County Hospital District	William Slaughter	(713) 873-4183
Harris County Sheriff's Office (Jail)	Vidya Yande, MD	(713) 755-7315
Houston Area Community Services	Tom Bryce	(713) 526-0555 x212
Legacy Community Health Services	Erica Gallardo	(713) 830-3087
Montrose Counseling Center	Helen Bailey	(713) 529-0037
St. Hope Foundation	Timika Sam	(713) 778-1300
UT Health Science Center	Virginia Wall	(713) 500-6440
Veteran's Administration	Belinda Rainer	(713) 791-1414 x5292

This system is designed to make obtaining services from different agencies easier for the clients. Please call one of the registration agencies above to schedule an appointment for your registration, prior to your intake at Bering Omega Community Services.

If you need further assistance or have questions please feel free to call a contact person at a registration site.

Step 2: Required Paperwork for Admission

You will need to bring the following documents to your intake appointment:

- 1. Doctor's Orders.** Your doctor must complete an order that shows the need for your attendance in the Day Treatment Program. (see attached form)
- 2. Physician's Statement.** Must contain the diagnosis of HIV or AIDS. (see attached form)
- 3. Proof of Identity.** Texas I.D. card, Texas Driver's License, school or state I.D. (I.D. **MUST** have picture.)
- 4. Proof of Income.** Current award letter, recent check stub, letter of support, or three consecutive recent bank account statements if living on savings. *If you are providing a letter of support, we need a rejection letter from Social Security within 60 days of intake.*

These documents *must* be updated **by you** every calendar year.

Make sure you have all required paperwork with you on the day of your intake. If you do not, this will delay your intake process.

Step 3: Set up an Intake Appointment

To set up an intake appointment with a program staff, please call 713-341-3751. This day is for you to meet with our staff and fill out all necessary paperwork.

General Day Treatment Program Information

Transportation

- If you live within a 5 mile radius, the program van can pick you up and drop you off. Pick up is 8:30am (must call in to schedule pick up by 8am) and drop off is 3:00pm.
- If you need assistance with transportation, we can help you get set up with St. Hope Transportation. They pick up between 7-8am and bring you to the care center. They will pick you up from our program around 1pm to take you back home.

What we offer

- The Day Treatment Program offers: medication management, breakfast, snacks, and lunch, field trips, book club, Bible study, peer/group classes, basic exercise class, arts & crafts, referrals, educational speakers, and dietitian services.
- On site staff: Manager, Activities Coordinator, Nurse, Food Service Coordinator. We usually have at least one volunteer from 8am-3pm.
- We are a smoke free environment.
- Your participation in day to day program activities will determine your eligibility for field trips.

Outside activities

- Once you are signed into the program, and in our care, and we ask you not to leave for any reason (to run an errand, etc.) until you are ready to sign out.
- You can be signed into our program and still utilize the dental and housing assistance services, if needed. We can help you meet your appointment.

General Day Treatment Program Guidelines

Clients are expected to follow the following guidelines:

- We encourage all clients to stay at least 4 hours to benefit from our program.
- Disrespect will not be tolerated (Examples: offensive language, rudeness, cursing, talk of sexual activities and threats)
- We require participation in at least two activities a day (see monthly calendar)
- All bags will be kept at front desk. If you need your bag, please ask a staff or volunteer to get it for you.
- Our attendance policy is that the client attends at least three (3) days per week. If you do not attend within a 90 day period, we must close your file and you will have to wait thirty (30) days to re-apply.
- All clients must abide by our non-smoking policy.

If rules cannot be followed, the staff has the right to write up clients. If written up, the client may be suspended or terminated from the program.

I have read and understand the Day Treatment information packet, including the program guidelines.

Client Signature

Date

BRING THIS PAGE TO YOUR INTAKE APPOINTMENT



PHYSICIAN STATEMENT

Patient Name: _____ **SS#:** _____

Date of Birth: _____

The patient's diagnosis is (please circle one): AIDS HIV+

Date of most recent C.B.C.: _____

Required values:

Hgb _____ **(14.0 – 18.0 g/dl)** **MCHC** _____ (32.0 – 36.0 %)

Hct _____ (40.0 – 54.0 %) **WBC** _____ (4.5 – 12.0 /mm3)

RBC _____ (4.50 – 6/10 M/mm3) **Plt Cnt** _____ (150.0 – 400.0 /mm3)

MCV _____ (82.0 – 101.0 03) **CD4** _____

MCH _____ (27.0 – 34.0 PG) **HIV Viral Load** _____

Medication	Dosage

DO YOU FEEL THAT THE PATIENT IS MEDICALLY FIT FOR THE PURPOSES OF RECEIVING ADULT DAY CARE SERVICES?

YES

NO

IF NOT, WHAT DO YOU SEE AS THE CONTRAINDICATION?

PRINT Physician Name:	Physician Signature	Date:

PHYSICIAN'S ADMISSION ORDERS

Adult Day Care/Day Treatment Program
Phone 713-520-6071 FAX 713-520-7854

Patient Name:	DOB:	SS#
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In addition to HIV/AIDS, the patient must have a functional disability, need for nursing intervention, or other medical/psychiatric need to be eligible for this program.

Diagnosis	PLEASE CIRCLE ONE	Comments/Orders
HIV Diagnosis	HIV or AIDS	Diagnosis date:
TB Diagnosis	TB test w/controls or CXR Date/results:	<i>NOTE: a TB evaluation must be done annually for continued Care Center participation.</i>
Special Diet or restrictions	YES or NO	
Physical Therapy evaluation and treatment	YES or NO	
Registered Dietician's evaluation and treatment	YES or NO	
Allergies	YES or NO	
Psychiatric Diagnosis	YES or NO	
Nursing Orders	YES or NO	
Restricted Activities	YES or NO	
Patient can self-medicate	YES or NO	
Behavioral Assistance	YES or NO	
Other Diagnosis	YES or NO	

Current Medications	Dose	Route

May we have standing PRN orders for the following?	Please circle one
Tylenol 325mg 2 p.o. Q 4-6 hr pain/fever at or above 101.5	YES or NO
Ibuprofen 400mg p.o. Q6 for pain/fever at or above 101.5	YES or NO
Maalox 30cc p.o. up to 4x's per day 20-60 minutes after meals	YES or NO
Milk of Magnesia 30cc p.o. 1-2x's QD for constipation	YES or NO
Immodium 2mg after each loose stool up to 4x's per day	YES or NO
Robitussin 15cc p.o. Q 6 hr for cough	YES or NO
Sudafed 60mg p.o. Q 4-6 hr	YES or NO
Multiple Vitamin 1 tab p.o. QD	YES or NO
Vitamin C 500 mg 1 tab QD	YES or NO
Betacarotene 25,000 I.U. 1 tab p.o. QD	YES or NO
Bacitracin (or triple abx ointment) for minor cuts and scrapes	YES or NO
Other:	YES or NO

Physician license #	PRINT physician name:	Phone:
Physician Signature:		Date:

BERING OMEGA Day Treatment Program

NAME:

PHONE #:

SHIFT: (mark which shift you will be attending for each day)

*Please note: AM shift: 7am-12:30pm

PM shift: 12:30pm-5pm

MONDAY: **AM** **PM**
TUESDAY: **AM** **PM**
WEDNESDAY: **AM** **PM**
THURSDAY: **AM** **PM**
FRIDAY: **AM** **PM**

Lunch will be served at each shift

Nursing available at each shift

Outings, speakers, activities at each shift

Friday Food bags given at each shift

Clients **MUST** attend at least 3 times a week for a four hour visit

Because of our high attendance and limited space, you will choose which shift you would like, but you must sign up and attend **ONLY** for that particular shift. This will help us not have to turn clients away.

If there is a day you would like to come that you did not sign up for, you can call the front desk that morning, at 713-341-3750, to be put on our waiting list.

I have read, marked, and understand the Bering Omega Day Treatment program changes. I agree to follow these guidelines.

Client Signature

Date

Bering Omega Staff

Date

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