Riverside Health
Adult Day Services

Hello!

Thank you very much for your interest in Riverside's Adult Day Service program. Many family members have found day services to be a great solution for them as caregivers and for their loved ones as participants. Our flexible Monday-Friday schedule allows you the option of having a family member participate every day or just certain days depending on your needs. The schedule is full of supervised activities, group interaction, exercise, nutritious meals & snacks- all at a surprisingly affordable price.

I am enclosing the following materials to get you started:

- ✓ Application for Admission
- ✓ Physical/TB Form (to be completed by participant's physician)
- ✓ Day Program Brochure
- ✓ Who We Serve
- ✓ Tips for Getting Started
- ✓ Convenient Admission Checklist
- ✓ Center's Closed Dates for the Year

Once you have completed the application and physical/TB, you may return them to the Center, fax them to 757-877-8430, or email them to tara.bartlett@rivhs.com. We will then schedule a convenient time for a functional interview at our Center or over the phone. If you have any questions or would like to stop by, just let me know. I look forward to meeting with you soon.

Sincerely,

Tara Hauschild

Tara Hauschild
Adult Day Services Director

Visit our website by scanning the QR code or **click here!**

Criteria for Admission

- ✓ Be 18 years or older
- ✓ Free from narcotic medication while at center
- ✓ Free from catheterization or ostomy
- ✓ Ability to communicate needs either verbally or non-verbally
- ✓ Ability to participate in activities
- ✓ Capable of understanding and following simple commands
- ✓ Is not a danger to themselves or others (no significant self harming or aggressive behaviors)
- ✓ Able to bear weight for transfer without assistance from a mechanical lift (i.e. able to utilize grab bars to transfer from wheelchair to toilet with moderate assistance)
- ✓ Must not require one to one care (i.e. cannot require constant redirection to prevent wandering)
- ✓ Be socially appropriate

Most importantly.... Be ready for a good time with great people!

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1010 Old Denbigh Blvd. • Newport News, VA 23602 • 757-875-2033

Monday–Friday:
7:30 a.m.–5:30 p.m.

One Saturday per month:
8:00 a.m.–4:00 p.m.

riversideonline.com/adultdayservices

Riverside Health
Adult Day Services

The More You Know

Average Cost of Services per month in Virginia in 2024

Nursing home care

Semi-private room [2]	**$8,669**
Private room [2]	**$9,825**

Community and assisted living

Adult day health care [2]	**$1,766**
Assisted living community [3]	**$6,513**

In-home care

Homemaker services [1]	**$6,101**
Home health aide	**$6,292**

Referenced from nadsa.org

Research has shown an increased number of unpaid caregivers over the past 5 years

21%
Report their health has been negatively impact by caregiving

26%
Care for someone with Alzheimer's disease or related dementia

24%
Provide care for more than 1 person

45%
Reported at least 1 financial impact

26%
Face challenges coordinating care

Adult Day Programs have show to assist PARTICIPANTS by reducing:

- ✓ Negative Behaviors
- ✓ Sleep Problems
- ✓ Cognitive Decline
- ✓ Physical Decline

Adult Day Programs have show to assist CAREGIVERS by reducing:

- ✓ Depression
- ✓ Stress
- ✓ Burden levels linked to caregiver
- ✓ health and wellbeing

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Adult Day Services

What's Our Purpose?

Adult Day Services is designed for adults 18 years and older who may need daytime support and supervision.

Participants may benefit from our services if they need:

- Help staying safe during the day
- Medical supervision or medication administration
- Support with reducing fall risks
- Encouragement to be more active
- Redirection or guidance
- Assistance with daily living activities

What We Provide Each Day

Meals & Snacks

- ✓ Morning snack
- ✓ Hot noon meal
- ✓ Afternoon snack

Activities & Engagement

- ✓ A variety of scheduled activities
- ✓ Opportunities to be active and engaged
- ✓ Encouragement to participate at each person's comfort level

Who We Serve

Our center supports individuals with a range of needs, including those living with:

- ✓ Alzheimer's disease or memory concerns
- ✓ Diabetes
- ✓ Stroke recovery
- ✓ Difficulty walking or moving around
- ✓ Intellectual Disabilities

Our Goal

We strive to provide a safe, supportive, and comfortable daytime environment where participants can enjoy social interaction, meaningful activities, and maintain their current abilities as long as possible.

Our ratio of 1 staff member for every 6 participants makes it easy for our team to provide unique care for each participant!

Why choose us

- We treat your loved ones like family – providing care with compassion, respect, and dignity.
- Person-centered care – services are tailored to meet each individual's unique needs and preferences.
- Willingness to listen and grow – we value feedback and continually work to improve.
- Flexible scheduling – options to fit your family's needs.
- Encouragement for independence – we help participants remain as independent as possible, for as long as possible.
- We strive to care for our participants as we would care for those we love.

Our team

- Certified Nursing Aides
- Registered Nurse
- Office Assistant
- Program Director

We strive to care for our participants as we would care for those we love.

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Riverside Adult Day Services

2026 Rate Schedule

Fee and Charge Schedule

Hours of Operation: 7:30am - 5:30pm Monday through Friday
1 Saturday per month 8:00am-4:00pm (*subject to participation*)

Daily Fees

Drop-In (no scheduled days)	$110.00 per day
2 Scheduled Days	$96.00 per day
3 Scheduled Days	$94.00 per day
4 Scheduled Days	$92.00 per day
5 Scheduled Days	$88.00 per day

Saturday openings are not included in the regular weekly schedule and will be treated as an additional day of service.

Late Fees

Late Pick-up Fee	$2.50 per minute after 5:30pm
Late Payment Fee	1.5% of amount due after 1st of month

Other Fees and Charges Information

- Missed Days: No credit will be issued unless participant is admitted to hospital or has an infectious illness with a doctor's note
- Additional days may be added as center schedule allows, based on contracted rate.
- A 30 day written notice is required to change, addendum, or withdraw from program.
- Participants may use up to five days as designated 'personal days' without incurring charges or fees for missed attendance.
- Charges for Saturday openings will be billed according to the participant's contracted rate.

Riverside Health

Riverside Lifelong Health
Adult Day Services
1010 Old Denbigh Blvd
Newport News, VA 23602
Phone: 757-875-2033 | Fax: 757-877-8430

riversideonline.com

Our Center will be closed the following dates in 2026:

Thursday, Jan. 1st,- New Year's Day

Monday, May 25th,- Memorial Day.

Friday, July 3rd,- Independence Day

Monday, Sept. 7th,- Labor Day

Thursday, Nov. 26th- Thanksgiving Day

Friday, Nov.27th

Friday, Dec. 25th,- Christmas Day

Our Center will be closing early at 4:00pm the following dates in 2026:

Thursday, Dec. 24th- Christmas Eve

Thursday, Dec. 31st- New Years Eve

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Riverside Adult Day Services Admission Checklist

Initial for All

- ☐ Physical/TB Exam completed within last 30 days
- ☐ Application for Admission Completed
- ☐ Vaccination Record Obtained

Medicaid Recipients Only

- ☐ Copy of UAI Obtained and Turned in
- ☐ CCC Plus Waiver Confirmed

After Physical/TB form, application for admission, and vaccination record turned in for all. The following documents will be given to participant/caregiver to be completed after receiving initial paperwork above.

- ☐ Functional Assessment Completed with Director
- ☐ Admission Agreement Signed
- ☐ Notice of Privacy Form Signed
- ☐ Medication From Completed in its Entirety and Signed
- ☐ Participant Rights form Signed
- ☐ Photo Consent Completed
- ☐ EMT Form Completed
- ☐ All Documents Turned In
- ☐ Start Date Established

Medicaid Recipients Only

- ☐ Medicaid Rights Form Signed
- ☐ Personal Care Form Completed
- ☐ All Medicaid Forms Turned In

RIVERSIDE

Adult Day Services

Admission Date:_____

Application for Admission

Participant's name _____ Sex _____

Address _____City_____State/Zip _____

Phone Home (____)_____ Cell (____)_____ Race _____

Date of Birth _____ Age_____ Marital Status _____

Place of Birth _____ U.S. Citizen Yes___ No ___

Religion _____ Participant's Social Security # _____

Current medical diagnosis _____

Participant's personal physician _____ Phone # (____)_____

Participant's personal dentist_____ Phone # (____)_____

How did you hear about us? _____

Spouse's Name _____

Participant's representative_____ Relationship to participant_____

Address _____City_____State/Zip _____

Phone Home (____)_____ Bus. (____)_____ Cell (____)_____

Email _____

Emergency Contacts other than above:

Name _____ Relationship to Participant_____

Address _____City_____State/Zip _____

Phone Home (____)_____ Bus. (____)_____ Cell (____)_____

Email _____

Name _____ Relationship to Participant_____

Address _____City_____State/Zip _____

Phone Home (____)_____ Bus. (____)_____ Cell (____)_____

Email _____

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Person Responsible for Payment of Services

Name_____ Relationship to participant_____

Address _____City_____State/Zip _____

Phone Home (____)_____ Bus. (____)_____ Cell (____)_____

Email _____

Personal Information

Does the participant have an Advance Directive? Yes ___ No___

Does the participant have a "Do Not Resuscitate" (DNR) order? Yes ___* No___

(*If you selected "yes", you will need to bring a copy of the DNR to be kept at the center so that the EMT's will be able to honor the order.)

Preferred hospital in non-emergency situation _____

Previous Occupation _____

Participant's interests/hobbies _____

Prior Military Service? Yes ___ No___

I certify that to the best of my knowledge, the above information is accurate. I further understand that this information will be kept confidential by Riverside Health System.

Participant's signature _____ Date_____

Participant representative's signature _____ Date_____

Riverside representative _____ Date_____

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Riverside Adult Day Services

Participant Physical Examination ☐ Pre-Admission ☐ Annual

Within the 30 days prior to admission, and annually thereafter, a participant shall have a physical examination. A TB assessment shall be obtained no earlier than 30 days prior to admission. (Annual TB testing is not required for participants.) Physicians, please complete this form in its entirety as all information on this form is required to meet Virginia Department of Social Services regulations.

Name _____

Address _____ Date of Birth _____

City, State, Zip _____ Telephone _____

Height _____ Weight _____ Blood pressure _____

All diagnoses and significant medical problems: **ICD Codes**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Significant medical history:

_____

_____

General physical condition, including a systems review as is medically indicated:

_____

_____

Known Allergies (food, medicine, other): **Description of reaction to allergen:**

_____ _____

_____ _____

_____ _____

_____ _____

Riverside Adult Day Services
Participant Physical Examination

Participant Name _____

Recommendations for care including:

Medications (Rx and OTC)	Dosage	Route	Frequency of administration

Special Diet or Food Intolerances:

_____

Therapy, treatments, or procedures participant is undergoing, or should receive, and by whom:

_____

_____

Restrictions or limitations on physical activities or program participation:

_____

_____

Does this person have the mental capacity to understand and sign legal documentation on their own? ☐ YES **or** ☐ NO

Is this person capable of administering their own medications without assistance? ☐ YES **or** ☐ NO

Is this person Ambulatory*? ☐ YES **or** ☐ NO
**Ambulatory means that the participant is physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area without the assistance of another person, or from the structure itself without the assistance of another person even if the participant may require the assistance of a wheelchair, walker, cane, prosthetic device or a single verbal command to evacuate.*
Please attach most recent vaccination record to this document.

If this is a pre-admission physical exam, please attach TB screening form.

Physician Signature _____ Date of Exam_____

Physician Printed Name _____

Address _____

Phone _____ Fax _____

Virginia Tuberculosis (TB) Screening and Risk Assessment Tool

For use in individuals 6 years and older

Use this tool to identify asymptomatic **individuals 6 years and older** for latent TB infection (LTBI)testing.

- The symptom screen and risk factor assessment may be conducted by a licensed healthcare provider (MD, PA, NP, RN, LPN). If a symptom or risk factor for TB is identified, further evaluation should also be performed by a licensed healthcare provider (MD, PA, NP, RN, LPN), however an RN or an LPN conducting evaluations must have an order by healthcare personnel with prescriptive authority consistent with Virginia professional practice acts for medicine and nursing.
- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment.
- A negative Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) does not rule out active TB disease.

First screen for TB Symptoms: ☐ None (If no TB symptoms present → Continue with this tool)

☐ Cough ☐ Hemoptysis (coughing up blood) ☐ Fever ☐ Weight Loss ☐ Poor Appetite ☐ Night Sweats ☐ Fatigue

If TB symptoms present → Evaluate for active TB disease

Check appropriate risk factor boxes below.

TB infection testing is recommended if any of the risks below are checked.

If TB infection test result is positive and active TB disease is ruled out, TB infection treatment is recommended.

☐ **Birth, travel, or residence in a country with an elevated TB rate ≥ 3 months**

- Includes countries other than the United States (U.S.), Canada, Australia, New Zealand, or Western and North European countries
- IGRA is preferred over TST for non-U.S.-born persons ≥ 2 years old
- Clinicians may make individual decisions based on the information supplied during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism < 3 months may be considered for further screening based on the risk estimated during the evaluation.

☐ **Medical conditions increasing risk for progression to TB disease**

Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunoileal bypass, solid organ transplant, head and neck cancer

☐ **Immunosuppression, current or planned**

HIV infection, injection drug use, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact to someone with infectious TB disease at any time**

☐ **None; no TB testing indicated at this time**

Patient Name _____ Date of Birth _____/_____/_____

Name of Person Completing Assessment _____ Signature of Person Completing Assessment _____

Title/Credentials of Person Completing Assessment _____ Assessment Date _____/_____/_____