



## Old Friends Club Program Overview

### Summary

- Each program is two days a week, for 5 hours per day.
- Our social respite programs are built on the same small-group dynamics that underpin support group systems, and cap membership for each program at 12 members.
- To ensure that scheduled respite is not prevented by an already-full program for the day, program membership is maintained on a monthly-basis, ensuring that your loved one's spot is always saved.
- Program fees are based on an all-inclusive rate of \$18/hour and billed at the average of 4.35 program weeks per month (\$792/month), so program fees are steady month-to-month.
  - o Flat rate membership fees include funds for program supplies/activity costs as well as a daily lunch and snacks.
  - o Program fees are prorated for partial months for new members, and for December due to DSNW's annual holiday closure.

### Program Suitability Guidelines

Old Friends Clubs do not provide medical services, health monitoring, or medication assistance, and are designed around socialization settings. Members must be able to:

- **Self-administer any medications needed during program times.**
  - o Program staff cannot administer medications and may assist only in reminding member or opening bottle.
- **Require minimal—if any—assistance eating**
  - o Program staff will assist with cutting/spreading if needed.
- **Maintain continence.**
  - o Programs utilize community spaces, leaving program staff unable to safely address incontinence issues.
  - o Members may require staff assistance using the restroom, either in cueing/guidance or in helping with clothing

### Current Programs (Beginning March 2023)

**Lynden Program:** Mon. - Tue., 9:30 – 2:30 p.m.

Sonlight Church, 8800 Bender Road, Lynden, WA 98264

**Bellingham Program:** Wed.- Th., 9:30 – 2:30 p.m.

CTK – Bellingham, 4173 Meridian Street, Bellingham, WA 98226

Mailing: 2950 Newmarket Street #210, Bellingham, WA 98226 • Phone:  
360.671.3316 • Email: [alz@alzsociety.org](mailto:alz@alzsociety.org)

Date of initial contact: \_\_\_\_\_ Location: \_\_\_\_\_ Start Date: \_\_\_\_\_  
(The day you are sending the form) (Preferred)

### CAREGIVER OFC INQUIRY

Name \_\_\_\_\_ Relation \_\_\_\_\_ Telephone # \_\_\_\_\_ text ok? \_\_\_\_\_

Email \_\_\_\_\_

Names of other care providers \_\_\_\_\_

Where did you learn about OFC? \_\_\_\_\_

### POTENTIAL MEMBER

Name \_\_\_\_\_ Age \_\_\_\_\_ Marital Status/Spouse's name \_\_\_\_\_

Living Situation \_\_\_\_\_ City of residence \_\_\_\_\_ How long? \_\_\_\_\_

Number of children \_\_\_\_\_ Do they provide care? \_\_\_\_\_

Diagnosis \_\_\_\_\_ Date of diagnosis \_\_\_\_\_

Medications \_\_\_\_\_ Can Member administer own meds? Yes No

Does Member use: Cane Walker Wheelchair

Assistance needed (toilet, eating, other cues) \_\_\_\_\_

Medical Hx (Stroke, depression, diabetes, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has care been needed \_\_\_\_\_

### OTHER SOCIAL HISTORY

Education/Degree \_\_\_\_\_

Occupation \_\_\_\_\_

Past interests/hobbies \_\_\_\_\_

Present interests \_\_\_\_\_

Veteran? \_\_\_\_\_ LTC Insurance? \_\_\_\_\_ POLST? Yes No  
(Portable Medical Orders)

### NEXT STEPS (Office Use Only)

Date of first visit: \_\_\_\_\_

Date Registration Form sent \_\_\_\_\_

Follow up: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_