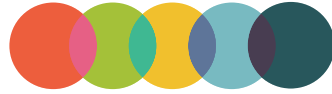

Senior Resource
ASSOCIATION

Promoting Independence in our Community

New Participant Admissions Packet

DayAway

VERO BEACH
694 14th Street

SEBASTIAN
815 Davis Street

Karen B. Rose Deigl
President/CEO Senior Resource Association, Inc.

seniorresourceassociation.org | 772.569.0760

Revision Date: 9 - 15 - 22

Senior Resource
ASSOCIATION

Promoting Independence in our Community

FOR OFFICE USE ONLY

DATE ADMITTED

DAYAWAY PARTICIPANT DATA SHEET

FULL NAME OF PARTICIPANT | DOB | SSN

STREET ADDRESS

CITY / STATE / ZIP

ETHNICITY | SEX | $ MONTHLY INCOME OF PARTICIPANT

HOW DID YOU HEAR ABOUT US?

INSURANCE INFORMATION

MEDICAID / MEDICARE IDENTIFICATION NUMBER

OTHER HEALTH INSURANCE COMPANY NAME(S) + POLICY NUMBER(S)

IDENTIFICATION OR WANDERING-PREVENTION PROGRAM NAME ❐ NOT ENROLLED

PHYSICIAN INFORMATION

NAME | PHONE NUMBER

RESPONSIBLE PARTY (LOCAL CAREGIVER)

NAME | RELATIONSHIP

EMAIL ADDRESS | HOME PHONE | CELL PHONE | WORK PHONE

ADDRESS ❐ SAME AS ABOVE

EMERGENCY CONTACTS/AUTHORIZED PICK-UP

NAME | PHONE NUMBER | RELATIONSHIP

NAME | PHONE NUMBER | RELATIONSHIP

NAME | PHONE NUMBER | RELATIONSHIP

NAME | PHONE NUMBER | RELATIONSHIP

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Promoting Independence in our Community

EMERGENCY TREATMENT CONSENT

I authorize emergency treatment at the nearest hospital in the event a family member or responsible party cannot be contacted.

____

PARTICIPANT NAME

____

SIGNATURE OF RESPONSIBLE PARTY

____

DATE

Senior Resource
ASSOCIATION

Promoting Independence in our Community

CONSENT TO PHOTOGRAPH

At times during your attendance at DayAway we may, as part of our activities, take video or still photographs.

These photographs may appear in the newspaper and social media or be viewed by persons to whom we are marketing our DayAway program. Please check your response in the appropriate box below. Your choice will remain in effect unless changed by you in writing.

❒ I CONSENT ❒ I OBJECT

____
PARTICIPANT NAME

____
SIGNATURE OF RESPONSIBLE PARTY

____
DATE

Senior Resource
ASSOCIATION
Promoting Independence in our Community

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize the Senior Resource Association to use and disclose my medical information for the purposes listed below:

- Treatment - to provide you with medical treatment or services and to manage and coordinate your medical care. For example, your protected health information may be disclosed to a business associate of the Department to determine your medical eligibility for Medicaid long-term-care services.
- Payment - to bill and collect payment for your health-care services. We may disclose or use your protected health information to obtain or justify payment for your health-care services from various payment sources including federal and state funding programs such as Medicaid.
- Healthcare operations - to evaluate the performance of our staff in caring for you and to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may also use your protected health information to: contact you as a reminder that you have a scheduled appointment for treatment or medical care, inform you of potential treatment alternatives or options, or inform you of health-related benefits that may be of interest to you.

I understand that the above information is necessary and will only be used by the Senior Resource Association or its authorized representatives as it pertains to the enrolled program.

I also understand by signing this form that:

1. I may be considered for this program, whereas refusal to either sign or submit needed information may make it difficult to arrange services to help me.
2. I have a right to inspect my own records, and can contest their validity, add data or request deletion of parts.

I further authorize the Senior Resource Association to use and disclose the following specific health and medical information for the below listed purpose(s):

1. Specific medical information consisting of diagnosis and prognosis of client, along with medications and dosages.
2. For the specific purpose of attending the DayAway Program.

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that the Senior Resource Association has already used or disclosed the information in reliance on this consent.

____
SIGNATURE OF RESPONSIBLE PARTY

____
SIGNATURE OF DAYAWAY REPRESENTATIVE

____
DATE

Revision Date: 9 - 15 - 22

Senior Resource
ASSOCIATION
Promoting Independence in our Community

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION (CONTINUED)

If Senior Resource Association is requesting this Authorization from you for our own use and disclosure, or to allow another health care provider or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization

2. You may inspect a copy of the protected health information to be used or disclosed

3. You may refuse to sign this Authorization

4. We must provide you with a copy of the signed authorization

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier, this Authorization shall remain in effect for the period the client remains in the DayAway program.

You may review the Senior Resource Association Notice of Privacy Practices for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. **Please verify that you have received a copy of our notice by placing your initials here: _____.**

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice; we will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment and health care operations purposed. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

____
SIGNATURE OF RESPONSIBLE PARTY

____
SIGNATURE OF DAYAWAY REPRESENTATIVE

____
DATE

Senior Resource
ASSOCIATION
Promoting Independence in our Community

PARTICIPATION AGREEMENT GENERAL CONDITIONS

Site Location: Senior Resource Association operates two DayAway Centers located in Vero Beach at 694 14th Street and in Sebastian at 815 Davis Street.

Days and Hours of Operation: DayAway is provided Monday through Friday 7:30 a.m. to 5:30 p.m., with the exception of the holidays observed by Senior Resource Association. The holiday list is included with the caregiver handbook and also posted in the center. We also may need to close due to unforeseen conditions, such as a hurricane, or other emergencies, with as much advanced notice as possible.

Services to be provided: Therapeutic Activities, Health and Nursing Services, Nutrition Services and Case Management Services.

Terms and Conditions: The DayAway Participant (hereinafter referred to as "participant") and/or other party responsible for payment (hereinafter referred to as "responsible party") accept that by signing this Agreement agree to abide by all the terms and conditions set forth in this Agreement.

Acknowledgment: The participant and/or responsible party signing this Agreement hereby acknowledge the following:

1. That each has received an original of this Agreement and any attachments thereto.
2. That each has been given an oral explanation of the services provided by DayAway and the charges therefore, including those services offered as part of the daily rate.
3. That each has been given an oral explanation of services and extra charges not included in the daily rate. DayAway will secure approval from the participant or other party signing this agreement prior to services not included in the daily rate.
4. That each has received a copy of the following Senior Resource Association documents:

A. Participation Datasheet
B. Services Provided
C. Emergency Treatment Consent
D. Participant Rights
E. HIPAA Policy
F. Admission and Discharge Policy
G. Grievance Procedure
H. Financial Agreement

Personal Property: It is understood that DayAway is not responsible for the participant's valuables, monies or clothing unless they are held in trust by DayAway for safekeeping. Property shall not be considered held in trust unless a written receipt has been given to the participant and/or responsible party.

____
SIGNATURE OF RESPONSIBLE PARTY

____
SIGNATURE OF DAYAWAY REPRESENTATIVE

____
DATE

Senior Resource
ASSOCIATION
Promoting Independence in our Community

DAYAWAY FINANCIAL AGREEMENT

Thank you for choosing Senior Resource Association (SRA) as your DayAway provider. We at SRA know it is important for participants and caregivers to read and understand our financial policies. Signing this DayAway financial agreement will acknowledge that you have read the document and that you agree to our financial terms and conditions.

Please initial by each statement below:

______ **1. RATES** I am ultimately responsible for all payment obligations arising out of care and guarantee payment for these services. The fee is expected to be paid in full either monthly or weekly, depending on my chosen plan. SRA's current rates are $11.00 per hour, with a two hour minimum and a $60.00 maximum per day, subject to change. SRA offers a weekly discounted rate of $225.00 (please see separate weekly discounted rate agreement for details). Cancellations or changes in the agreed schedule shall require a 48-hour notice.

______ **2. INSURANCE** I acknowledge that SRA does not accept assignment for third party insurance benefits. It is the responsibility of the participant and/or responsible party to bill private third party insurance. However, SRA may be able to provide support documentation to the participant and/or responsible party for insurance purposes.

______ **3. BILLING** I understand, as an hourly or daily participant, that monthly statements will be presented for payment the following month after services have been rendered. I must notify SRA of any errors or objections to the billing statement. If there is a discrepancy with my account, it is my responsibility to contact the Finance Department to address the problem or to discuss a workable solution. SRA will provide a 30-day notice for any rate changes. Lunch and snacks are provided; there is no adjustment in the rate if I make other arrangements for lunch or snacks.

______ **4. PAYMENTS** I acknowledge that payment of any account balance is due at SRA's Finance Department, 694 14th Street, Vero Beach, Florida within fourteen (14) days of receipt of my billing statement. If payment is two (2) weeks overdue, the participant will be unable to attend until the account is brought up to date. If I need to make special arrangements for payment, I will contact SRA's Finance Department to determine if I am eligible for a mutually agreeable alternative payment plan. Partial payments may be accepted and applied, without waiver, at the discretion of SRA. Acceptance of any partial payment shall not extend any time period, cure any default, or be deemed to satisfy any remaining balance due. A twenty-five dollar ($25.00) late fee will be imposed monthly for any balance remaining outstanding for over forty-five (45) days. If any balance on my account is over ninety (90) days past due, my account will be in default and may be referred to a collection agency.

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DAYAWAY FINANCIAL AGREEMENT (CONTINUED)

_____ **5. PAYMENT TYPE** I understand that SRA accepts payment by check, cash, money order, debit cards or credit cards (Visa, MasterCard or ACH Payment). If payment is made by check and it is returned or declined for any reason, my account will be charged a surcharge of $35.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution.

_____ **6. DROP-OFF/SIGN-IN PROCEDURE** I am aware of the Drop-Off/Sign-In procedure as follows: The earliest the participant may be dropped off is 7:30 a.m. I need to bring the participant into the facility and sign in with a DayAway staff member. If the participant is here after 5:30 p.m., an additional $1.00 per minute will be charged.

_____**7. COLLECTIONS** I will be responsible for all costs of collection for non-payment on account. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, I understand that SRA has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care.

_____ **8. COMMUNICATION** I authorize SRA personnel to communicate by mail, voicemail, and/or e-mail according to the information provided in the participant registration information. SRA, or any agent or servicer of the participant's account, may use any information I have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact me for purposes related to my account, including debt collection.

_____ **9. AGREEMENT** I acknowledge and agree to this Statement. Questions about these policies may be addressed to the Finance Department, 772.569.0760 or mailing address SRA 694 14th Street, Vero Beach, Florida.

PARTICIPANT NAME	PHONE NUMBER
PRINTED NAME OF FINANCIALLY RESPONSIBLE PARTY	EMAIL
SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY	BILLING ADDRESS
DATE	

Senior Resource
ASSOCIATION
Promoting Independence in our Community

ENTIRE AGREEMENT

I (we) hereby acknowledge that I (we) have read this page and the preceding pages. This Agreement constitutes the entire agreement between and/or among the parties, and it may not be amended except by written agreement of the parties. I (we) further acknowledge that the participant, and/or responsible party signing this Agreement have made the above promises and representations in order to induce the Senior Resource Association to enter into this Agreement, and the participant and/or responsible party signing this Agreement acknowledge that the Senior Resource Association upon entering into this Agreement, is relying upon the truthfulness of the promises and representations of the participant and/or other party signing this Agreement herein.

____
PRINTED PARTICIPANT NAME

____
SIGNATURE OF PARTICIPANT

____
DATE

____
PRINTED NAME OF DAYAWAY REPRESENTATIVE

____
SIGNATURE OF DAYAWAY REPRESENTATIVE

If the participant is unable to physically sign his/her name, the participant shall sign by making a mark. If this is the manner in which the Agreement is signed, the witness shall attest that the participant was aware that he/she was signing an Agreement and that it was his/her intent to sign.

____
PRINTED NAME OF FINANCIALLY RESPONSIBLE PARTY

____
SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY

____
DATE

____
BILLING ADDRESS

In the event that the participant has appointed a representative to control his/her assets, and even if such appointment has not been made through a legal document, the participant's representative shall be fully bound to the extent of those assets to the terms of this Agreement.

Senior Resource
ASSOCIATION

Promoting Independence in our Community

CANCELLATIONS OR CHANGES

Planned cancellations or changes shall require 48-hour notice. Failure to provide the foregoing notice shall result in a charge of the daily rate.

ASSIGNABILITY

This agreement is fully assignable by the Senior Resource Association. In the event that the license is transferred such that a new licensee operates the DayAway, this Agreement shall automatically be assigned to the new licensee and shall be fully binding upon the parties. A reasonable notice of any assignment shall be given, but shall not affect the right of Senior Resource Association to assign or the validity of the assignment. Upon the occurrence of an assignment, all unearned deposited funds shall be transferred to the assignee in a timely manner, and the assignor shall be held forever harmless thereafter.

Senior Resource
ASSOCIATION
Promoting Independence in our Community

SRA COMPLAINT PROCEDURE

Upon receipt of a verbal or written complaint from a participant regarding the provider, Senior Resource Association (SRA), the Director of Adult and Senior Services will review the nature of the complaint with the participant and discuss available options for resolution of the problem. Appropriate action is then taken by the Director of Adult and Senior Services, or if appropriate, the President/CEO to address the complaint.

Upon receipt of a verbal or written complaint from a participant regarding an SRA Case Manager, the Senior Support Services Manager will review the nature of the complaint with the participant and discuss available options for resolution of the problem. Appropriate action is then taken by the Senior Support Services Manager, or if appropriate, the Director of Adult and Senior Services to address the complaint.

All participants are informed at the time of their initial assessment and on annual reassessment of their right to file a complaint against SRA as well as the complaint procedure and their right to have the complaint reviewed. If a participant is not satisfied with the action taken to address their complaint, they have the right to request that the complaint be reviewed by the President/CEO.

The participant's complaint is documented in the SRA Provider Complaint Log along with the actions taken by the Director of Adult and Senior Services, to resolve the complaint. Follow-up by the Director of Adult and Senior Services is conducted to assure participant satisfaction with the action taken. This follow-up is also to be documented in the Complaint Log.

All complaints must be logged in the Complaint Log, which includes the following:

- Date of complaint
- Complainant's name
- The nature of the complaint and the circumstances
- Name of the person who is subject of the complaint
- The product or the services which are subject of the complaint
- Resolution or Action Taken
- Date of Resolution of Complaint

SRA COMPLAINT PROCEDURE (CONTINUED)

I have been informed of the Senior Resource Association's (SRA) complaint procedure. I understand that I have the right to file a complaint against SRA as a provider of services as well as against subcontractors providing services for SRA, and I have the right to have my complaint reviewed if I am not satisfied with the action taken to address it.

I understand that I may make a complaint if I am dissatisfied with service, the quality and timeliness of service, or any other complaints not related to termination, suspension, or reduction in services.

If the complaint is against Senior Resource Association as a provider of case management or DayAway, then I can contact the Director of Adult and Senior Services to seek resolution.

____

SIGNATURE OF RESPONSIBLE PARTY

____

SIGNATURE OF DAYAWAY REPRESENTATIVE

____

DATE

Senior Resource
ASSOCIATION
Promoting Independence in our Community

PARTICIPANT NAME ______________________

HEIGHT ____________ WEIGHT ____________

MEDICAL HISTORY

DIRECTIONS: Check box if applicable to participant

- ❐ Medication (needed during stay at day care)
- ❐ Medication allergies
- ❐ Coumadin or blood thinner
- ❐ Seizures **IF YES, ARE THEY CONTROLLED BY MEDICATION? ___ YES ___ NO**
- ❐ Congestive heart failure
- ❐ Heart attack **DATE ________**
- ❐ Pacemaker
- ❐ Hypertension
- ❐ Hypotension
- ❐ Stroke **DATE ________ SIDE AFFECTED: ___ LEFT ___ RIGHT ___ N/A**
- ❐ Parkinson's
- ❐ COPD/pulmonary problems
- ❐ Supplemental oxygen
  HOW ADMINISTERED: **DOSE:**
- ❐ Thyroid problems **TYPE: ___ HYPER ___ HYPO**
- ❐ Diabetes **___ INSULIN ___ ORAL MED ___ DIET ALONE**
- ❐ Chronic pain **WHERE IS PAIN LOCATED?**
- ❐ Vision problems **(CATARACTS, GLAUCOMA ETC.)**
- ❐ Wears glasses
- ❐ Hearing problems
- ❐ Hearing aids
- ❐ Memory problems **TYPE:**
- ❐ Depression

Senior Resource
ASSOCIATION

Promoting Independence in our Community

PARTICIPANT NAME ______________________

HEIGHT ______________ WEIGHT ______________

MEDICAL HISTORY

DIRECTIONS: Check box if applicable to participant

- ❐ Needs help with eating
- ❐ Swallowing problems
- ❐ Choking: ___ FOOD ___ DRINK
- ❐ Requires assistance in the bathroom
- ❐ Incontinent ___ BLADDER ___ BOWEL ___ BOTH
- ❐ Wears pull-ups
- ❐ Difficulty walking ___ WALKER ___ CANE ___ WHEELCHAIR
- ❐ Gets lost or wanders off*
- ❐ Fall risk IF YES, HOW MANY FALLS IN PAST 6 MONTHS?
- ❐ Personality MARK ALL THAT APPLY
  ___ FRIENDLY ___ OUTGOING ___ SHY ___ AGITATED ___ ANXIOUS
- ❐ Other Important Medical Information to Know

____

____

____

____

____

____

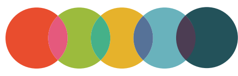
____

____

____

____

*DayAway is a secured and locked facility, but this helps us to plan activities and understand your loved one better.



Promoting Independence in our Community

____
PARTICIPANT NAME

PERSON-CENTERED CARE/SOCIAL HISTORY

Please complete the below questions as detailed as possible. The information you provide in this form is extremely helpful in fully getting to know the participant, providing the custom care plan, and the most beneficial activities for the participant.

General Information:

Name of Spouse______________________________ Living? ☐ Yes ☐ No
Children? ☐ Yes ☐ No How Many? ____________________
Place of Birth______________________________
State/Countries Lived In______________________________
Travel Experience______________________________
Favorite Topic(s) of Discussion______________________________

School & Work History:

College____________________ Degree Obtained____________________
Favorite Subject(s) in School______________________________
Former Occupation(s)______________________________
Military Service____________________ How Long? ____________________
Languages Spoken______________________________
Does the Participant Read? ________ Books _______ Type of Books ______________
Magazines_______ Newspaper________ Online________

Personal Interests:

Hobbies______________________________
Prefer Indoor or Outdoor______________________________
Favorite Animal(s)______________________________
Favorite Food(s)______________________________
Favorite Color(s)______________________________
Favorite Sport____________________ Favorite Sport Team(s)____________________
Favorite Type of Music______________________________
Favorite Music Artist(s)______________________________
Play any Musical Instruments______________________________
Favorite Movie(s)______________________________
Favorite Movie Star/Performer______________________________
Favorite Movie Genre______________________________
Other Special Skills/Talents/Interests ______________________________
____

Family Goals & Information:

Any sensitive topics of discussion to be avoided? ______________________________
____
____

What are the Participants' future goals and what are they/the family hoping to achieve by attending DayAway? ______________________________
____
____

Senior Resource
ASSOCIATION

Promoting Independence in our Community

PARTICIPANT NAME

DEMENTIA SPECIFIC INFORMATION AND REFERRAL

DIRECTIONS: Check box if needed by the Participant or Caregiver

- ❒ Medical Services
- ❒ Counseling
- ❒ Medical Planning
- ❒ Legal Planning
- ❒ Financial Planning
- ❒ Safety and Security Planning
- ❒ Disaster Planning
- ❒ Driving Assessment
- ❒ Transportation Coordination
- ❒ Wandering Prevention
- ❒ Caregiver Support Group
- ❒ Dementia- Specific Educational Materials
- ❒ Comments:

I acknowledge that I have received information and referrals on the resources that I have requested. I understand that I can request additional information at any time as needed.

SIGNATURE OF RESPONSIBLE PARTY

DATE

Senior Resource
ASSOCIATION
Promoting Independence in our Community

HANDBOOK

I acknowledge receipt of the **Caregiver and Participant Handbook**. I understand I can request clarification of anything I do not understand.

____
PARTICIPANT NAME

____
PRINTED NAME OF RESPONSIBLE PARTY

____
SIGNATURE OF RESPONSIBLE PARTY

____
DATE

Senior Resource
ASSOCIATION

Promoting Independence in our Community

Senior Resource Association, Inc.
WAIVER OF LIABILITY AND INDEMNITY AGREEMENT

Participant Name: ____
(Please Print)

Caregiver Name: ____
(Please Print)

IN CONSIDERATION for being permitted to utilize the services and programs of the Senior Resource Association, Inc. (SRA) and/or for the participant above to so participate for any purpose, including, but not limited to, observation or use of facilities or equipment, or participation in any off-site program affiliated with SRA, the undersigned, on behalf of himself or herself and such participant(s) and any personal representatives, heirs, and next of kin (hereinafter referred to as "the undersigned") hereby acknowledges, agrees and represents that he or she has inspected and carefully considered such premises, equipment and facilities and/or the affiliated program and that the undersigned finds and accepts same as being safe and reasonably suited for the use or participation by the undersigned and such participant(s).

In addition, the undersigned acknowledges that novel coronavirus (''COVID-19") infections have been confirmed throughout the United States, and in particular Indian River County, Florida. In accordance with the most recent guidance and protocols issued by the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), the Florida Department of Health (FDH), for slowing the transmission of COVID-19, the undersigned hereby agrees, represents, and warrants that neither the undersigned nor such participant(s) shall visit or utilize the facilities, services, and programs of SRA (other than any exclusively online services and programs) within 14 days after (i) returning from highly impacted areas subject to a CDC Level3 Travel Health Notice, (ii) exposure to any person returning from areas subject to a CDC Level z3 Travel Health Notice, or (iii) exposure to any person who has a suspected or confirmed case of COVID-19. The CDC Travel Health Network is continuously updating this list and the undersigned agrees that they are aware of this list and the countries listed. The undersigned agrees to check the CDC Travel Health Notices list (https://wwwnc.cdc.gov/travel/notices) prior to utilizing the facilities, services, and programs of SRA, on a daily basis if necessary. The undersigned hereby agrees, represents, and warrants that neither the undersigned nor such participant(s) shall visit or utilize the facilities, services, and programs of SRA if he or she (i) experiences symptoms of COVID-19, including, without limitation, fever, cough or shortness of breath, or (ii) has a suspected or diagnosed/confirmed case of COVID-19. The undersigned agrees to notify SRA immediately if he or she believes that any of the foregoing access/use restrictions may apply.

SRA has taken certain steps to implement recommended guidance and protocols issued by the Public Health Agencies for slowing the transmission of COVID-19, including, without limitation, the access/use restrictions set forth above. The undersigned acknowledges and agrees that SRA may revise its procedures at any time based on updated recommended guidance and protocols issued by the Public Health Agencies and further agrees to comply with SRA's revised procedures prior to utilizing the facilities, services, and programs of SRA. The undersigned further acknowledges and agrees that, due to the nature of the facilities, services, and programs offered by SRA, social distancing of 6 feet per person among participant(s) and their caregivers in an adult day care setting is not 100% enforceable. The undersigned fully understands and appreciates both the known and potential dangers of utilizing the facilities, services, and programs of SRA and acknowledges that use thereof by the undersigned and/or such participant(s) may, despite SRA's reasonable efforts to mitigate such dangers, result in exposure to COVID-19, which could result in quarantine requirements, serious illness, disability, and/or death.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER SRA FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO, OBSERVATION OR USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY ON-SITE OR OFF-SITE PROGRAM AFFILIATED WITH SRA, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING:

THE UNDERSIGNED, ON HIS OR HER BEHALF AND ON BEHALF OF SUCH PARTICIPANT(S), HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE SRA, its directors, officers, employees, volunteers and agents from all liability to the undersigned or such participant(s) and all personal representatives, assigns, heirs, and next of kin of the undersigned or such participant(s) for any loss or damage, and any claim or demands on account of any property damage or any injury to, or an illness or the death of, the undersigned or such participant(s) (or any person who may contract COVID-19, directly or indirectly, from the undersigned or such participant(s) whether caused by the negligence, active or passive, of SRA or otherwise while the undersigned or such participant(s) are in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with SRA.

THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS SRA, its directors, officers, employees, volunteers and agents, and each of them, from any loss, liability, damages or costs they may incur, whether caused by the negligence, active or passive, or otherwise while the undersigned is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with SRA. The undersigned understands and agrees that SRA is not required to provide insurance to cover the undersigned or such participant(s) in the event they suffer illness, injury, death, property loss, theft or damage of any sort upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with SRA.

The undersigned agrees and acknowledges that use of SRA facilities and services, and participation in SRA programs, may involve inherent danger and risk, including, without limitation, the risk of physical illness or injury, death or property damage. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR, AND RISK OF ILLNESS, BODILY INJURY, DEATH OR PROPERTY DAMAGE to the undersigned or such participant(s) due to negligence, active or passive, or otherwise while in, about or upon the premises of SRA and/or while using the premises or any facilities or equipment thereon or participating in any program affiliated with SRA. The undersigned acknowledges that any illness or injuries that the undersigned or such participating participant(s) contract or sustain may be compounded by negligent first aid or emergency response of the Releasees and waive any claim in respect thereof. THE UNDERSIGNED further expressly agrees that the foregoing ASSUMPTION OF RISK, RELEASE AND WAIVER OF LIABILITY, AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the laws of the State of Florida and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I HAVE CAREFULLY READ AND VOLUNTARILY SIGN THIS ASSUMPTION OF RISK, RELEASE AND WAIVER OF LIABILITY, AND INDEMNITY AGREEMENT AND FURTHER AGREE THAT NO ORAL REPRESENTATIONS, STATEMENTS OR INDUCEMENT APART FROM THE FOREGOING WRITTEN AGREEMENT HAVE BEEN MADE. I AM AWARE THAT BY AGREEING TO THIS AGREEMENT I AM GIVING UP VALUABLE LEGAL RIGHTS, INCLUDING THE RIGHT TO POSSIBLY RECOVER DAMAGES FROM SRA IN CASE OF ILLNESS, INJURY, DEATH OR PROPERTY LOSS OR DAMAGE, INCLUDING, FOR THE AVOIDANCE OF DOUBT AND WITHOUT LIMITATION, EXPOSURE TO COVID-19 AT ANY SRA FACILITY OR PROGRAM AND ANY ILLNESS, INJURY OR DEATH RESULTING THEREFROM. I UNDERSTAND THAT THIS DOCUMENT IS A PROMISE NOT TO SUE AND A RELEASE OF AND INDEMNIFICATION FOR ALL CLAIMS. IF SIGNING ON BEHALF OF AN INCAPACITATED ADULT: I ALSO UNDERSTAND THAT IF I AM GUARDIAN OR ATTORNEY-IN-FACT THIS AGREEMENT IS MADE ON BEHALF OF MY LEGAL WARD(S) AND I REPRESENT AND WARRANT TO SRA THAT I HAVE FULL AUTHORITY TO SIGN THIS AGREEMENT ON BEHALF OF SUCH PERSON(S).

I have read and understand the terms of this Assumption of Risk, Release, and Waiver of Liability, and Indemnity Agreement and agree to its terms.

SIGNATURE _______________ DATE _______________

IF OTHER THAN INDIVIDUAL, STATE CAPACITY _______________

EMERGENCY CONTACT NAME _______________ EMERGENCY CONTACT NUMBER _______________