Bacharach
INSTITUTE FOR REHABILITATION

Dear Friend,

Thank you for your interest in the Arthritis Swim Class sponsored by the Atlantic County Division of Intergenerational Services and the NJ Chapter of the Arthritis Foundation. The 1- hour class is a series of gentle exercises in a heated pool at Bacharach's main campus in Pomona.

To be eligible for 10 free classes you must have a diagnosis of Arthritis, be age 60 or older and live in Atlantic County. If you do not meet the criteria, but would still like to participate, the cost is $10 per class. Please note that a bathing suit must be worn and Bacharach cannot provide transportation.

Enclosed is the 3 page application. The first 2 pages ask for your contact information and demographics. The page with the red border must be signed by your doctor saying that you are healthy enough to take the class.

Mail back the completed application in the enclosed self-addressed stamped envelope. If you lose the envelope please send to the address below.

Bacharach Foundation
Jamie Hoagland
61 West Jimmie Leeds Road
Pomona, NJ 08240

Please allow about 10 days for someone from Bacharach to contact you after the application is mailed.

Sincerely,

Jamie Hoagland

Jamie Hoagland
Marketing/ Foundation Liaison
Phone: (609) 748-5250
Email: jmcaviney@bacharach.org

BACHARACH INSTITUTE FOR REHABILITATION

SPONSORED/FUNDED THROUGH ATLANTIC COUNTY DIVISION OF INTERGENERATIONAL SERVICES
ARTHRITIS POOL CLASS
APPLICATION

Date of Request_____ Phone #_____

Name_____
Address_____
_____

Are you eligible for:
Medicaid Yes No
PAAD Yes No
Senior Gold Yes No

Is your household income $9,570 and under for individual or $12,830 and under for couple? Yes No

Please check all that apply:

___Male ___Female

___Atlantic City
___Absecon
___Brigantine
___ Buena Boro (Minotola, Landisville)
___Buena Vista Twp. (Collings Lake, Newtonville, Richland, Milmay Buena)
___Corbin City
___Egg Harbor City
___Egg Harbor Twp. (English Creek, Cardiff, Bargaintown, Scullville)
___Estelle Manor
___Folsom Boro (Folsom)
___Galloway Twp. (Cologne, Pomona, Absecon Highlands, Oceanville)
___Hamilton Twp. (Mizpah, Weymouth, Mays Landing, McKee City, Laureldale)
___Hammonton
___Linwood
___Longport
___Margate
___Mullica Twp., (Sweetwater, Elwood, Devonshire)
___Northfield
___ Plesantville
___ Port Republic
___Somers Point
___Ventnor
___Weymouth Twp. (Dorothy, Belcoville)

___African American
___Hispanic
___Asian
___American Indian
___Non-Minority

___60-64
___65-70
___71-75
___76-80
___81-85
___85 +

___I would like to donate to this program Signature_____

For further information on other available Intergenerational Services, please call NJ Ease 1-888-426-9243

For internal use only:

___Frail/disabled
___Vulnerable

___Eligible
___Ineligible

___Minority Poverty
___Other Poverty

Comments_____
_____

Starting Date:

Signature_____

Participant Application and Release Form

Atlantic County offers a grant for Arthritis Foundation Aquatic Program participants at Bacharach if:

Bacharach
INSTITUTE FOR REHABILITATION

You live in Atlantic County.
You are 60 years of age or older.
You have a diagnosis of arthritis.
You are eligible for: Medicaid, PAAD, Senior Gold or your household income is under $9,570 if you are single, or under $12,830 for a couple.

Classes meet Tuesdays or Thursdays from 12:30 to 1:30.

The grant is for 10 classes if you qualify. After the 10 classes you may continue to come but you must pay $100.00 for the next 10 classes, and so on.

Please fill out the information below and sign the release.

Return this sheet, the physician consent form and the form for the county in the envelope provided. If you qualify, we will call to schedule you.

Name:_____ Date of birth: _____

Address:_____

City: _____ Zip: _____

Phone: _____

Emergency contact: _____ Relationship: _____

Phone: _____

If my application for the Arthritis Foundation Aquatic Program is accepted, and I am permitted to participate, I understand and agree that neither the Arthritis Foundation nor any co-sponsoring organization or facility, nor their respective chapters, officers, directors, employees, agents, members or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from participation in this program. I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

Signature:_____ Date: _____

Please answer the following questions.

Do you have a diagnosis of arthritis? Yes No
Do you have any blood pressure problems? Yes No
Do you take blood pressure medication? Yes No
Is your blood pressure under control? Yes No
Do you have control of your bowel and bladder? Yes No
Are you independent in walking in your home as well as in and out of the pool? Yes No
Do you have any open areas, wounds or sores on your skin? Yes No

Physician Consent Form

Arthritis Foundation Aquatic Program

Bacharach
INSTITUTE FOR REHABILITATION

Dear Doctor,

The Arthritis Foundation, NJ Chapter, is collaborating with Bacharach Institute to offer the Arthritis Foundation Aquatic program. This series of recreational warm water pool activities will be led by trained personnel and is performed in 10 class increments.

A physician's consent form is required only once a year, unless there is more than a 3 month lapse in attendance or a medical problem occurs.

The program includes range of motion, muscle strengthening, and endurance-building activities. Persons with total joint involvement or moderate to severe joint involvement may require the individualized attention of a physical or occupational therapist. If your patient requires this instruction, you may want to refer him or her to a therapist prior to participation in this program.

My patient, _____, has the following diagnosis (type of arthritis/rheumatic disease) or other pertinent information:

_____

_____

_____

I approve of the Arthritis Foundation Aquatic program for the above patient:

_____ No limitations

_____ Specific recommendations or precautions (i.e., cardiac, HTN, etc.)

_____

_____ Joint replacements (please list) _____

Physicians name _____

Address _____

Phone _____

Signature _____ Date _____