



A Non-Profit, 501(c)(3) Corporation

THE ARTHRITIS FOUNDATION AQUATIC EXERCISE PROGRAM

- To increase mobility & strength for those with arthritis, fibromyalgia, or other degenerative autoimmune diseases
- To assist with recovery after stroke or surgery
- To provide a continuing exercise program

Three easy steps:

1. Get approval for warm-water exercise from your doctor
2. Mail, fax or bring in the approval
3. Call or come in to schedule your exercise classes

57121 Sunnyslope Drive, Yucca Valley, CA 92284

(760) 365-9661(Phone)

(760) 994-1337(Fax)

www.mbahs.org

mbahs@mbahs.org

Water Temperature

People with joint and muscle discomfort prefer warmer water temperatures. The warmer water increases the elastic qualities of the muscle leading to an increased range of motion. The recommended temperature range for the program is 83-88°F. Extremely high water temperatures (over 90°F) may feel very soothing but can be dangerous for exercising or if you have cardiovascular problems. MBSSC maintains a strict water temperature of between 89-90°F.

Guidelines

While the exercises in the Arthritis Foundation Aquatic Program (AFAP) have been designed to be within the capability of most people with arthritis, there are guidelines you should observe.

- ◆ If you have had surgery or have severe joint problems, please talk with your doctor before starting the AFAP (or any exercise) to check whether you should avoid any specific exercises. Regardless, we require a note allowing you to exercise in warm water.
- ◆ If you have any neck problems, check with your doctor before doing any neck exercises.
- ◆ Listen to your body. If an exercise hurts, **stop!** If you get tired, **rest!**
- ◆ If you experience any chest pains, dizziness or nausea, **stop exercising** and tell the instructor or pool manager.
- ◆ Only gently move an inflamed joint (one that is hot, swollen, or painful) through its range of motion.
- ◆ Exercise at your own pace. Do not overexert yourself or do more repetitions than are comfortable for you. Do only the exercises demonstrated by the instructor.
- ◆ Breathe in a normal rhythmic pattern. If you find yourself running out of breath, slow down. Counting or singing out loud will help regulate your breathing.
- ◆ Do not lock or stiffen your joints when exercising. Avoid arching your back, and do not allow your knees to go past your toes when bending your knees.
- ◆ Do not allow anyone to assist you in moving any of your body parts.
- ◆ If needed for balance or safety, hold onto the pool wall or railing.
- ◆ If you experience chilling, inform the instructor, leave the pool, and get dressed.
- ◆ If you have any questions, feel free to talk to either the instructor or pool manager any time before, during or after the program.
- ◆ Enjoy yourself, have fun and meet new friends!

Arthritis Foundation Aquatic Program

Monday through Friday

AFAP – Basic	9 AM, 10 AM, & 11 AM
AFAP – Plus	8 AM and 1 PM
Special Needs	12 PM

Monday and Thursday Evening Classes
are held at 5:30pm for our working clients.

Volunteer instructors certified by the Arthritis Foundation lead the warm-water exercise classes.

- ◆ AFAP - BASIC offers exercises designed by the Arthritis Foundation bringing pain relief, better health and mobility to clients with arthritis, strokes and other debilitating conditions.
- ◆ SPECIAL NEEDS CLASSES are a slower-paced program to increase flexibility and improve muscle tone especially beneficial for those who have had a stroke, are post-surgical, or have other impairments
- ◆ AFAP – ACTIVE CLASSES is a program with a moderate cardiovascular segment. Participants must be able to tolerate 15 minutes of standing or walking without pain, fatigue or shortness of breath and be comfortable with motion.

MONTHLY FEES:

- 1 TIME A WEEK \$13.00 A MONTH
- 2 TIMES A WEEK \$26.00 A MONTH
- 3 TIMES A WEEK \$39.00 A MONTH
- Or For Each Visit \$4.00 per visit

- ◆ Financial Assistance is available on a limited basis

Pool Rules

1. Rinse off before going into the pool.
2. NO skin or hair conditioners in the showers. (Shower gel is allowed... NO BAR SOAP!)
3. NO Shampooing hair!
4. Please take off loose band-aids before entering pool.
5. Always walk down the pool steps backwards, holding on to the rail.
6. For your safety, please do not walk on the narrow side of pool deck.
7. While waiting for your class to begin please remain QUIET!
Feel free to visit in the Senior Activity Center.
8. Vacate the pool promptly at the end of class.
9. Do not enter pool until 10 min. before the hour.
10. This is the Arthritis Foundation Aquatic Program, swimming is not allowed.
11. The dumbbells are not to be used during class.
12. You must participate in the class. You may not do "Your own thing".
13. Update the receptionist of any changes in your health or personal information.
14. Repeated failure to attend a class without notifying the receptionist may result
in you being removed from the class list.
15. Maximum number of participants in the pool per class will be twelve (12).
16. If a class is not your regularly scheduled class you will only be admitted after
the regularly scheduled participants are accommodated. See 14 above.
17. No open wounds.

Always enjoy the class and have a great day!

Participant Tips for the Arthritis Foundation Aquatic Program

Welcome to the Arthritis Foundation Aquatic Program!

The Arthritis Foundation Aquatic Program is a warm water recreational exercise program designed specially for people with arthritis. Its purpose is to reduce pain and stiffness. It may also increase range of motion of the joints. The program is taught by Arthritis Foundation or trained personnel. It consists of sessions lasting 45-60 minutes, two to three times a week. Swimming ability is not necessary to participate in the program.

Suggested Swimwear

Suggested swimwear includes:

- ◆ Blouson swimsuits that are easy to get on and off.
- ◆ Shorts
- ◆ T-Shirts
- ◆ Aquatic or beach shoes (not thongs, scuffs, or mules) or terry cloth slippers with non-skid soles. Rubber soles may decrease pain and will help absorb any jarring during exercise.
- ◆ Exercise clothing/specially designed aquatic clothing
- ◆ Disposable latex gloves (for warmth).
- ◆ Swimming cap

**Morongo Basin Senior Support Center
Arthritis Foundation Aquatic Program**

Physician Information Form

**Applicant--Please complete this section.
(Please print)**

Name: _____

I give permission for Dr. _____ to complete this physician information form.

Applicant's Signature

Date

Physician--Please complete this section.

The above named patient has the following diagnosis:

Please indicate if there are any special precautions or reasons why this patient should limit his/her participation or any reasons why, in your opinion, this patient should not participate.

Physician's Signature

Date

Physician's Phone Number

Arthritis Foundation Aquatic Program Participant Application and Release Form

General Information:

1. Mr./Mrs./Ms _____ Date of Birth _____

3. Address: _____

City: _____ State: _____ ZIP Code: _____

4. Home Phone: _____ Bus./Cell Phone: _____

5. Gender: M/F (Circle One)

6. Type of Arthritis or other similar condition (if known): _____

Participant Release Form:

If my application for the Arthritis Foundation Aquatics Program is accepted, and I am permitted to participate in the program, I understand and agree that neither the Arthritis Foundation nor any co-sponsoring organization or facility, nor members, or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury that I may suffer during or resulting from my participation in this program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damage that I may have or that may hereafter accrue to me arising out of or in any way connected with my 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 and will have provided written approval from my doctor for my participation before I am allowed to participate in any manner whatsoever.

By signing this, I also agree to allow MBSSC to use any pictures, likenesses, photos, or names as part of their promotion of this non-profit organization.

Signature _____ Date _____

The following will be completed by MBSSC staff:

Date of Enrollment: _____ Initial Class

Schedule: _____

DHPC: Yes ___ No ___ Caregiver Needed: Yes ___ No ___

How did participant hear about MBSSC?

CONFIDENTIAL EMERGENCY CARD

Name: _____ Date: _____

Address: _____

Phone Number: (____) ____ - ____ Bus./Cell _____

Emergency Contact: _____

Relationship: _____ Phone Number: (____) ____ - ____

Doctor: _____ Phone Number: (____) ____ - ____

PRESCRIPTION DRUGS

Name: _____

Please list your current medications:

Please list allergies to
medications: _____

Project/Activity Title:
Morongo Basin Adult Health Services

Case Number: 123-18227/1021

Name/Address of Contractor Agency:
Morongo Basin Adult Health Services Corporation
P.O. Box 106
Yucca Valley, CA 92286

Date of Issue:
_____ Original: Beginning:09/01/08
_____ Amendment #

BENEFICIARY QUALIFICATION STATEMENT

This form has the purpose of providing information needed to qualify the use of federal Community Development Block Grant (CDBG) funds for the project/activity described above. This statement must be completed and signed by the person (or legal guardian of the person) requesting to receive benefits from the described project/activity. Only one statement per person, per year is required.

Please answer each of the following questions.

1. This question helps you determine the size of your household. For this question a household is a group of related or unrelated persons occupying the same house with at least one member being the head of the household. Renters, roomers, or borders cannot be included as household members. **How many persons are in your household?** _____

2. This question asks if you are from a low- and moderate-income household. For this question a list of the 2008 EXTREMELY LOW-INCOME, LOW-INCOME and LOW- AND MODERATE-INCOME categories* are presented below. Please add up the combined gross annual income of all persons in your household from all sources of income. **In the blank provided, write (yes) or (no) if your combined gross annual income is equal to or less than the EXTREMELY LOW-INCOME _____; LOW-INCOME _____; OR LOW AND MODERATE-INCOME _____ amount for the number of persons in your household.**

	Number of Persons in Your Household			
	1	2	3	4
EXTREMELY LOW-INCOME	\$14,000	\$16,000	\$18,000	\$20,000
LOW-INCOME	\$23,300	\$26,650	\$29,950	\$33,300
LOW- AND MODERATE-INCOME (COMBINED)	\$37,300	\$42,650	\$47,950	\$53,300

	Number of Persons in Your Household			
	5	6	7	8
EXTREMELY LOW-INCOME	\$21,600	\$23,200	\$24,800	\$26,400
LOW-INCOME	\$35,950	\$38,650	\$41,300	\$43,950
LOW- AND MODERATE-INCOME (COMBINED)	\$57,550	\$61,680	\$66,100	\$70,350

COUNTY OF SAN BERNARDINO DEPARTMENT OF COMMUNITY DEVELOPMENT AND HOUSING

Project/Activity Title:
Morongo Basin Adult Health Services

Case Number: 123-18227/1021

Name/Address of Contractor Agency:
Morongo Basin Adult Health Services Corporation
P.O. Box 106
Yucca Valley, CA 92286

Date of Issue:
_____ Original: Beginning:09/01/08
_____ Amendment #

3. Please indicate how you identify yourself by checking **only one (1)** of the following choices:

	Hispanic	Non-Hispanic
White	<input type="checkbox"/>	<input type="checkbox"/>
Black/African American	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>
American Indian/Alaskan Native	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
American Indian/Alaskan Native & White	<input type="checkbox"/>	<input type="checkbox"/>
Asian & White	<input type="checkbox"/>	<input type="checkbox"/>
Black/African American & White	<input type="checkbox"/>	<input type="checkbox"/>
Amer. Indian/Alaskan Native & Black/African American	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Other	<input type="checkbox"/>	<input type="checkbox"/>

4. Please check whether you belong to a Female Headed Household: Yes No

5. Please describe the **condition** that would qualify you as being considered in one of the following presumed low- and moderate-income categories: abused child, battered spouse, elderly person, homeless person, disabled adult, illiterate person, or migrant farm worker:
(description) _____

ACKNOWLEDGMENT AND DISCLAIMER

I CERTIFY UNDER PENALTY OF PERJURY THAT INCOME AND HOUSEHOLD STATEMENTS MADE ON THIS FORM ARE TRUE.

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SIGNATURE: _____ PHONE: _____

The information you provide on this form is for Community Development Block Grant (CDBG) program purposes only and will be kept confidential.

*Taken from 2008 Section 8 Low-Income and Very Low-Income Limits.



Participant Release Form

COMPLETE ALL SECTIONS - PLEASE PRINT OR TYPE

First Name:	MI:	Last Name:	
Street Address/ Apt.#:			
City:	State:	Zip:	
Home Phone:	Alternate Phone:	Email:	
Do you have arthritis? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what type?			

I understand and agree that there are risks, both foreseeable and unpredictable, associated with any exercise or education program. I am aware of these risks and agree that my participation is at my own risk. I hereby agree that neither the Arthritis Foundation, nor any co-sponsoring agency 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 my participation in the Arthritis Foundation Program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future Arthritis Foundation program.

I understand that this Participant Release Form has important legal consequences and limits my ability to recover money if I am injured as a result of my participation in this program. I have been given the opportunity to discuss its terms and consequences with an attorney of my choosing if I wish to do so.

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.

I understand and agree that the goal of the Arthritis Foundation and the co-sponsoring facility is to provide a safe program environment, free from disruption or harassment. To this end, the Arthritis Foundation and the co-sponsoring agency reserve the right to deny admission of those individuals whose behavior is disruptive, or who harass other program members or staff.

I understand and agree that a copy of this form will be provided to the Arthritis Foundation as well as any co-sponsoring agency or facility.

Privacy Notice: The Arthritis Foundation respects the privacy of each class participant. The Arthritis Foundation would like to provide you with information about other programs, services and opportunities. To indicate any preferences about how you are contacted, check off the appropriate boxes:

I prefer that the Arthritis Foundation contact me about the issues below by the following methods (check all that apply):

Advocacy	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Email	<input type="checkbox"/> No contact
Volunteering	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Email	<input type="checkbox"/> No contact
Arthritis Foundation Newsletters, Publications, Programs & Services	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Email	<input type="checkbox"/> No contact
Special Events and Other Fundraising Opportunities	<input type="checkbox"/> Mail	<input type="checkbox"/> Phone	<input type="checkbox"/> Email	<input type="checkbox"/> No contact
I do not want the Arthritis Foundation to share my name and address with other companies or organizations				<input type="checkbox"/>
I do not want to be contacted by the Arthritis Foundation				<input type="checkbox"/>

Signature

Date

Office use: Aquatic Aquatic DW Aquatic JA Exercise Self-Help Tai Chi Other:
Facility Name and Location: