Office(401) 320-8099 **FAX (**401) 320- 8091 **Email**: andradeadcri@gmail.com **Website**: http://andradeadc.com

ADMISSION APPLICATION FOR ANDRADE ADULT DAY CARE INC

Name ***Date of Birth***

Address

City, State, Zip Code

Home Phone ***Cell Phone***

EMAIL:

INSURANCE NAME AND GROUP NUMBER AND POLICY NUMBER

SOCIAL SECURITY NUMBER

PLEASE SUBMIT COPY OF INSURANCE CARD

Case Manager Name

Phone

Emergency Contact Name *Phone Number*

Emergency Contact Name: *Phone Number*

List all Diagnosis (Medical and Psychiatric)

Primary Physician's Name *Phone Number*

Psychiatrists Name: *Phone Number*

Allergies: Food/Medication

Background Criminal Information

Have you been convicted of any misdemeanors or felony(s) Please circle: YES NO

If yes please list:

Interest and Hobbies

List Hobbies and Interest

Release for Medical and/or Psychological Information

I authorize Andrade Adult Day Care Inc. to obtain patient medical information such as physical exams and psychiatric evaluations from the above physicians. This information may be faxed. These documents will be necessary for my involvement in the Andrade Adult Day Program.

Participant Signature . ***Date***

(I attest that all information above is accurate and correct. I understand if I provide willingly inaccurate information this may jeopardize my enrollment To Andrade Adult Day Care Inc.).

Witness Signature ***Date***

Please contact Greg Andrade (401) 320-8099 for questions or concerns.