Application for Enrollment to Adult Day Services/Fall Prevention Services

I'm interested in applying for: _____ Adult Day Services _____ Fall Prevention

Client Information:

Applicant Name: ____

Age: _________ Date of Birth: _____/_____/______ SSN: _____ - _____ - _______

Gender: _____ M _____ F Height: ________ Weight: ________

Highest Education Level: ________________

Previous Occupation: __________________ Workplace: ________________

Age of Retirement: ______ Adjustment to Retirement: ____Good ____Difficult

Veteran: _____ Yes _____ No Service Branch: ________________________

Marital Status: ____ Married ____ Single ____ Divorced ____ Separated ____ Widowed

Living Arrangements:

Present Address: ____

City: __________________ State: __________________ Zip Code: __________________

Primary Phone Number: ______________________

Applicant Lives: _____ Lives Alone _____ Spouse _____ Relative _____ Hired Caregiver

_____ Other

Explain if Other:

____

____

Primary Caregiver: **(**If applicable**)**

Name: _________________________________ Relationship to Client: ______________________

Address: ____ City: ___________ State: ___________

Zip Code: ___________ Email address: _________________________________

Work Phone: ________________________ Cell Phone: _______________________

Is primary Caregiver employed?

_____ Full time _____ Part time _____ Does not work outside the home

Does Primary Caregiver attend a support group? _____ Yes _____ No

Power of Attorney Name: _______________________________

Phone Number: ____

Medical Information:

Doctor's Name: _____________________________ Specialty: ___________________

Address: ____ City: _____________

State: _________ Zip Code: __________ Phone Number: _______________________

Please list any medications the client is currently taking: ____________________________
____
____
____

Has applicant had any falls within the last 6 months: _____ Yes ______ No

Has applicant ever had a fall risk assessment? ____ Yes ____ No

Does client have Alzheimer's Disease/Dementia? _____ Yes _____ No

Does client have any mental illness? ____ Yes ____ No

Please list if answered yes: ____

Does client have any developmental disability? _____ Yes _____ No

Please list if answered yes: ____

Emergency Contact & Persons Authorized to Transport Client:
(Other than primary contact)

Contact 1:

Name: ______________________________ Relationship to Client: ________________

Address: ____

City: ______________________ State: ______________ Zip Code: ______________

Phone Numbers: Home-__________________ Cell- __________________

Work-____________________

Contact 2:

Name: _______________________________ Relationship to Client: _______________

Address: ____

City: _____________________ State: ______________ Zip Code: _____________

Phone Numbers: Home-___________________ Cell- __________________

Work- ____________________

Insurance Information (only fill in applicable spaces):

Medicare ID Number: ____________________ Part A____ Part B _____

Medigap Insurance Co: _______________ Policy Number: ________________________

Medicaid ID Number: ___________________ Waiver program: _____________________

Long Term Care Insurance Co: ____________ Policy Number: ____________________

Enrolled in Veterans Affairs Adult Day Program Benefit: Yes___ No ___

Other Insurance Information:

____

Billing Address if different from Present Living Address:

Street: ____ City: ______________

State: _____________ Zip Code: ________________

Activities for Daily Living			
Please Check Appropriate Boxes:			
Activities	**By Self**	**Needs Help**	**Unable**
1. Dressing			
Shoes and stockings			
Outer Clothing			
Under Clothing			
2. Diet			
Feeds Self			
Prepares Meals			
3. Personal Hygiene			
Bathing			
Mouth Care, Dentures			
Shampoo			
Shaving			
Toileting			
4. Mobility			
In and Out of Car			
Walking			
Climbing Stairs			
Transfers to toilet			
Manages Wheelchair			
Uses Walker, Cane			
5. Takes Medication			

The remainder of this section is for Adult Day Service applicants only. If only enrolling in Fall Prevention Center, just sign at the bottom of page.

Family goals for Day Care: _____ Socialization _____ Stimulation _____ Family Respite
_____ Supervision _____ Other

Please list if other: ____

Preferred days and times for applicant to attend our center:

_____ Monday ____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Arrival time: ____________ Departure time: ____________

How did the caregiver hear about this program?

____

____

Transportation

How will the participant get to and from Adult Day Services? (Check all that might apply)

- ☐ Immediate family
- ☐ Extended family and friends' network
- ☐ Paid Home helper/aide
- ☐ Pulaski Area Transit
- ☐ New River Senior Services program
- ☐ Radford Community Transit program
- ☐ Medicaid transportation provider

Other: ____________________

Name of person completing this form:____________________________________

Applicant/Responsible Party Signature___________________________________

Date: ______________

Mail Completed Form to: **Pulaski Adult Day Service & Fall Prevention Center**
P.O. BOX 877
211 Fifth Street
Dublin, VA 24084