Hope House

ADULT DAY CARE SERVICE

P.O. BOX 1051, PAGO PAGO, AMERICAN SAMOA 96799
PHONE: 684-699-2101 EMAIL: dspp.hopehouse@gmail.com

Instructions:

- Fill out all requested information by printing or typing (except signatures).
- Attach pages if needed for additional information.
- Once complete, mail, fax, or scan and email application to the **dspp.hopehouse@gmail.com.**
- After receiving the application, Hope House will call and set up an appointment for a visit and for the applicant to be evaluated.

Admission Application

Applicant Name____
(Last) (First) (Middle)

Address____
(Street/Apt.) (City) (State) (Zip)

Phone________________Social Security #__________Religion ______________

Sex (circle) M F Age ____ Date of Birth___/___/_____Place of Birth (city/state) ____________
(MM) (DD) (YYYY)

Marital Status (circle) Married Single Divorced Widowed Name of spouse (if living): ____________

With whom does applicant live?____________________Relationship____________

Alternate emergency contact______________________Phone ____________

Address____
(Street/Apt.) (City) (State) (Zip)

Applicant Health History

List any major operations, chronic illnesses, and medical conditions ____________________

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Personal Physician__________________________Phone ____________

Address____
(Street/Apt.) (City) (State) (Zip)

Preferred hospital ____

Pharmacy______________________________ Phone ____________

Medicare/Insurance Information

- ☐ Part A Claim # ______________
- ☐ Part B Claim # ______________
- ☐ Other insurance coverage ____________________________

Admission p. 2 Name ___________________________________

What assistance is required in the following areas?

- ☐ Walking, Standing Explain ____________________
- ☐ Toileting Explain ____________________
- ☐ Bathing Explain ____________________
- ☐ Eating Explain ____________________

Dietary Requirements

- ☐ Regular diet
- ☐ Low sodium
- ☐ Diabetic
- ☐ Other Explain ____________________

Current Medications	Dosage	Times Given

Is supervision or help required with medications? Yes No (circle) Explain (if yes) ____________________

Requested starting date____________________Days: (circle) Monday Tuesday Wednesday Thursday Friday

Transported by Family (Relationship)_______________Other (Relationship) ______________________________

Transportation assistance required ____________________

What additional special needs does the applicant have? (i.e., need for socialization, supervision, etc.) ____________________

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Name, address, and phone number of individual or agency responsible for payment of adult day care services

Name____Phone ____________________

Address____
(Street) (City) (State) (Zip)

Applicant signature____________________________________ Date ____________________

Signature of person completing this form_______________________ Relationship ______________