DAY BREAK ADULT DAY HEALTH CARE CENTER

APPLICATION FOR ADMISSION

PLEASE FILL OUT FORM COMPLETELY

GENERAL INFORMATION					
Name of Applicant		**Medical Record #:**			
Gender Male Female	**Date of Birth**	**Age**	**Place of birth (City, State)**		
Street Address		**City**		**State**	**Zip Code**
SS #	**Marital Status (circle one)** Single Married Widowed Divorced Seperated		**Participant home phone #**		
Caregiver	**Relationship to applicant**		**Home #** / **Cell #**		
Street Address		**City**		**State**	**Zip Code**
Emergency Contact #1	**Relationship to Applicant**		**Home #** / **Work #** / **Cell #**		
Street Address		**City**		**State**	**Zip Code**
Emergency Contact #2	**Relationship to Applicant**		**Home #** / **Work #** / **Cell #**		
Street Address		**City**		**State**	**Zip Code**

FINANCIAL/INSURANCE INFORMATION					
Medi-Cal ID#		**Managed Care Name:**			
Service Date:	**Issue Date:**	**Managed Care #**			
Financially Responsible Party	**Relationship to Applicant**		**Home #** / **Cell #**		
Street Address		**City**		**State**	**Zip Code**

HEALTH INFORMATION				
Name of Physician			**Phone #** ( )	
Street Address		**City**	**State**	**Zip Code**
Mobility devices used (circle one) None Walker Wheelchair Cane		**Primary Language**		

Advanced Directive

Has the patient executed an Advanced Directive? (Durable Power of Attorney for Health Care and/or Directive to Physician?)

☐ **Yes** ☐ **No**

ADHC has made Advanced Directive forms available to me

☐ **Yes** ☐ **No**

Name/Signature of Person Completing Application	**Relationship to Applicant**	Date