DiVinity N HumAnity Adult Day Center

Participant Intake Application

Empowering Individuals with Dignity, Purpose, and Compassion

Participant Information

Full Name: _____
Date of Birth: _____ Age: _____ Gender: _____
Address: _____
City: _____ State: _____ ZIP Code:_____
Phone Number: _____ Email: _____
Preferred Contact Time: _____

Emergency Contacts

First Emergency Contact Full Name: _____
Relationship: _____
Primary Phone: _____
Alternate Phone: _____

Second Emergency Contact Full Name: _____
Relationship: _____
Primary Phone: _____
Alternate Phone: _____

Medical & Insurance Information

(This information will be used for billing usage.)

Primary Diagnosis: _____
Secondary Diagnosis (if any): _____
Allergies: _____
Current Medications:
_____
Primary Care Physician: _____ Phone: _____
Insurance Pay: [ ] Yes [ ] No

Insurance Provider: _____ Policy Number: _____

Medicaid #: _____ Medicare #:_____
Private Pay:[ ] Yes [ ] No

Other Coverage Details: _____

Functional & Personal Care Needs

Mobility (check all that apply):
[ ] Independent [ ] Uses Walker [ ] Uses Wheelchair [ ] Needs Assistance
Communication:
[ ] Verbal [ ] Nonverbal [ ] Uses Assistive Device
Feeding:
[ ] Independent [ ] Needs Assistance [ ] Tube Feeding
Toileting:
[ ] Independent [ ] Needs Assistance [ ] Incontinent
Special Bathroom Needs: _____
Additional Support Needs (check all that apply):
[ ] Medication Reminders [ ] Behavioral Support [ ] Sensory Support
[ ] Visual/Hearing Impairment [ ] Mental Health Support [ ] Transportation
[ ] Other: _____

Services Requested

[ ] Full-Day Program
[ ] Part-Time Program
[ ] Life Skills Development
[ ] Recreational Activities
[ ] Therapy or Behavioral Support
[ ] Transportation Services
[ ] Other: _____

Behavioral & Social Information

Does the participant have a behavior plan? [ ] Yes [ ] No
If yes, please attach a copy and summarize below:
_____
Known triggers or behaviors to be aware of:
_____
Favorite activities, hobbies, or social interests:

_____
Social Comfort Level: [ ] Outgoing [ ] Shy [ ] Depends on environment

Military & Veteran Information

Insurance Provider:_____

Policy Number:_____

Group Number(if applicable):_____
Is the participant a veteran? [ ] Yes [ ] No
Branch of Service: _____
Years of Service: _____
Receiving VA Benefits: [ ] Yes [ ] No
Additional Notes: _____

Legal & Guardianship Information

Legal Guardian (if applicable): _____
Relationship: _____ Phone: _____
Power of Attorney or Guardianship Docs Attached: [ ] Yes [ ] No

Consent & Authorization

Please check each box and sign below:
[ ] I certify that all information provided is accurate to the best of my knowledge.
[ ] I authorize DiVinity N HumAnity, Inc. to provide services as outlined.
[ ] I grant permission to contact my emergency contact(s) and healthcare providers.
[ ] I understand that my information will be handled in accordance with HIPAA privacy laws.

Signature of Participant or Guardian:_____
Date: _____

Office Use Only

Date Received: _____
Staff Initials: _____
Notes:
_____