Enrollment Application

Services (Select all that apply)

Adult Day (full day)_____ Adult Day (part day)_____ Overnight Respite_____

Referred By: _____

Today's Date (MM/ DD/ YYYY):_____ Desired Start Date _____

Potential Client's Information

Full Name:_____

Address:_____

Second Address (Apt. Bldg., etc.):_____

City:_____ State:_____ Zip:_____

Phone : _____ Type: Mobile____ Landline____

ID / Driver's License:_____

Gender: ____Male ____Female Date of Birth (MM/ DD/ YYYY):_____

Race / Ethnicity: _____ SSN#:_____

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widow

Billing Information

Bill To Name:_____

Address:_____

Second Address (Apt. Bldg., etc.):_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Care Partner / Emergency Contact Information

Primary Care Partner's Name: _____

Relationship to Guest_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

ID Verification:_____

Email:_____

POA?:_____

Emergency Contact #1

Name:_____

Address:_____

Second Address (Apt. Bldg., etc.):_____

City:_____ State:_____ Zip:_____

Relationship to Guest:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Email:_____

Emergency Contact #2

Name:_____

Address:_____

Second Address (Apt. Bldg., etc.):_____

City:_____ State:_____ Zip:_____

Relationship to Guest:_____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Email:_____

Guest Information

Hobbies and Interests:_____

_____

_____

_____

Support systems/services in use:_____

_____

Military Branch / Dates (if applicable):_____

Physician's Name & Address:_____

_____

Physician's Phone:_____

Diagnosis / Health Conditions

Though the Center does not provide medical care, the information requested is useful and necessary for providing the best care for each client.

CIRCLE ALL CONDITIONS THAT APPLY

Alzheimer's / Dementia	Glasses	High Blood Pressure
Anxiety/Depression	Arthritis	High Cholesterol
Confusion	Asthma	HIV / AIDS
Stroke	Bladder/Kidney problems	Mental Illness
Mobility problems	COPD	MS / MD
Walker / Cane / Wheelchair	Dermatitis	Pacemaker
Swallowing problems/choking	Diabetes	Parkinson's
Eating problems / disorder	Emphysema	Seizures / Epilepsy
Dentures	Heart condition	Others: _____
Hearing Aids	Heart issues	_____

Allergies (include food & medications and what happens when taken): _____

_____

Medications taken regularly and for what reason: _____

_____

_____

Dietary Restrictions:_____

_____

Guest or Care Partner's Signature:_____