



Office Use Only
Start _____
Days M T W Th F
Mileage _____
Trans _____

APPLICATION FORM

Name _____ Date _____

Address _____ Phone _____

City _____ Zip _____ Soc Sec # _____

Place of Birth _____ Date _____

Sex M F Marital Status: Married Single Widowed Divorced

If married: Name of Spouse _____ Date of Marriage _____

Do you live alone with spouse with other _____ (name of

other) Religion Catholic Jewish Protestan Other Parish

Church : _____

Name of clergy _____

Spouse, children, relatives or friends: List in order of whom to contact if necessary:

Name _____ Relationship _____

Address _____ Home phone _____ Cell _____

City _____ zip _____ Business Phone _____

Name _____ Relationship _____

Address _____ Home phone _____ Cell _____

City _____ Zip _____ Business Phone _____

Name _____ Relationship _____

Address _____ Home Phone _____ Cell _____

City _____ Zip _____ Business Phone _____

Name _____ Relationship _____

Address _____ Home Phone _____ Cell _____

City _____ Zip _____ Business Phone _____

Medical Information

Primary Physician _____ Phone _____

Other Physician _____ Phone _____

Hospital to be used in case of emergency _____

Medicaid number _____

1. Date of last physical examination _____

2. Date of last doctor visit _____

3. Physical & Mental Health Problems Onset Onset

4. Allergies _____

5. If diabetic, the diabetes is controlled by (check one)

_____ medication _____ insulin _____ diet

6. Current medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Is there any physical/medical problem that restricts activities? Yes_____ No_____
 If yes, explain _____

8. Is there a need for a supportive device for mobility? Yes_____ No _____
 If yes, do you use a cane, walker, brace, prosthesis, wheelchair, other?_____

9. Is there a hearing problem? _____

Do you use a hearing aid? Yes _____ No _____ Right ear _____ Left ear _____

10. Is there a vision problem) _____

Do you wear eye glasses _____yes _____No

11. Bladder : Controlled? Yes_____ No _____

12. Bowels: Controlled? Yes_____ No _____

13 Diet: Regular _____ Diabetic _____ Low salt _____

Low Fat _____ Bland _____ Soft _____

Mental Health

1. Memory: Remote Past Good _____ Fair_____ Poor_____

Recent Past Good _____ Fair_____ Poor_____

Present Good_____ Fair_____ Poor_____

2. Is there a time of day when memory and /or thinking process is clearer?

Yes_____ No_____

If yes, when: _____

Financial Information

The cost of one day participation is _____. The cost of transportation is _____ and _____ cents a mile.

If you wish your cost to be considered on the sliding scale fee schedule, please complete this form.

Income (Please list monthly amount)

Social security benefits.....\$_____

SSI\$_____

Private pension.....\$_____

Savings\$_____

Interest on savings\$_____

Family.....\$_____

Other sources (specify).....\$_____

Total\$_____

Total monthly cost of living

Rent/mortgage payments....\$_____

Property taxes.....\$_____

Utilities.....\$_____

Phone.....\$_____

Food.....\$_____

Clothing.....\$_____

Health Care.....\$_____

Health Insurance.....\$_____

Other Insurance.....\$_____

Miscellaneous.....\$_____

TOTAL.....\$_____

Participants Signature _____ Date _____

Caregiver's Signature _____ Date _____

I hereby apply for admission to

Applicants Signature _____ Date _____

We request the signature of caregivers of the applicant to indicate their interest and support of the applicant's participation in the _____

Signature _____ Date _____

Signature _____ Date _____

Billing Information:

Name _____

Address _____

Days of Attendance Preferred: (at least two days a week are required)

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Hours of Attendance:

Arrival time _____ Departure time (after 3:30pm) _____

Transportation Requirements: _____ provides transportation (within _____ miles) only when caregivers cannot)

_____ Both ways _____ One way _____ None _____ One way, from _____

How did you first hear about _____?

_____ Flier _____ Doctor's name _____

_____ Newspaper Which paper? _____

_____ Social worker _____

_____ Church Bulletin? Which church? _____

_____ Agency _____

_____ Telephone Book _____ Clergy Name _____

_____ Alzheimer Group Which Unit? _____

_____ Church _____

_____ Council on aging

_____ Friend Name _____

_____ Passport _____

_____ ESP _____

Who encouraged use of _____ services?

Check appropriate responses

Doctor _____

Social Worker _____

Agency _____

Clergy _____

Church _____

Family _____

Friend _____

Other _____