



## ADULT DAY CARE CENTER APPLICATION/ASSESSMENT

### A. Participant Information:

Full Name \_\_\_\_\_ Age \_\_\_\_\_

Preferred Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Birthplace \_\_\_\_\_

Directions to Home

\_\_\_\_\_  
\_\_\_\_\_

Present Living Situation \_\_\_\_\_

Marital Status S M W D Spouse \_\_\_\_\_ If Widowed, When \_\_\_\_\_

SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Medicare \_\_\_\_ Yes \_\_\_\_ No Medicaid \_\_\_\_ Yes \_\_\_\_ No

Medicaid # \_\_\_\_\_

Supplemental Insurance \_\_\_\_ Yes \_\_\_\_ No

If yes, specify \_\_\_\_\_  
(Company Name and Policy Number)

Former Occupations \_\_\_\_\_

Educational Level Completed \_\_\_\_\_ Ability to Read \_\_\_\_ Yes \_\_\_\_ No

Veteran \_\_\_\_ Yes \_\_\_\_ No War \_\_\_\_\_ Branch of Service \_\_\_\_\_

Power of Attorney for Legal Affairs? \_\_\_\_\_

Guardian \_\_\_\_\_

Durable Medical Power of Attorney? \_\_\_\_\_

Advanced Directives: Living Will \_\_\_\_ Yes \_\_\_\_ No / Do Not Resuscitate Form: \_\_\_\_ Yes \_\_\_\_ No

**(If DNR order is in effect, an original must be on file at Generations Crossing)**

**B. Caregiver Information:**

Name of Caregiver(s) \_\_\_\_\_

Address \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

If Employed, Where? \_\_\_\_\_ Work Phone \_\_\_\_\_

List the names of two persons (other than caregivers) who may be contacted in the event of an emergency:

Name	Address	Relationship	Phone (home, work, and cell)
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1. \_\_\_\_\_

2. \_\_\_\_\_

**C. Health Information:**

Primary Health/Diagnosis \_\_\_\_\_

\_\_\_\_\_

Other significant conditions \_\_\_\_\_

\_\_\_\_\_

Mental/Emotional/Psychiatric Conditions \_\_\_\_\_

Allergies \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_ Date last admitted \_\_\_\_\_

Other Physicians Rendering Care:

Name	Type of Care	Address	Phone #
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1. \_\_\_\_\_

2. \_\_\_\_\_

Other Services Currently Receiving (Please give agency name and phone number). Needed in Day Care?

Therapy (Physical/Speech/Occupational): \_\_\_\_\_

In Home Care: \_\_\_\_\_

<b>Office Use Only:</b>	DNR Status Reviewed	Medication Policy Reviewed	Change of Clothes Policy Reviewed
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## ACTIVITIES OF DAILY LIVING ASSESSMENT

Please check the appropriate box.

ACTIVITY	NEEDS COMPLETE ASSISTANCE	NEEDS SOME HELP	IS ABLE TO DO WITH USE OF DEVICE	INDEPENDENT
Bathing				
Dressing				
Transferring				
Eating/Feeding				
Bowel				
Bladder				
Walking				
Wheeling				
Stair Climbing				
Mobility				
Meal Prep				
Housekeeping				
Laundry				
Money Management				
Transportation				
Shopping				
Using Phone				
Home Maintenance				

Has the participant experienced any of the following behaviors?

**Wandering** \_\_\_\_ Yes \_\_\_\_ No    **Aggression** \_\_\_\_ Yes \_\_\_\_ No    **Confusion** \_\_\_\_ Yes \_\_\_\_ No

## LEISURE ACTIVITIES

Please place an   X   in the space next to the activity your family member currently does or would have interest. Please write in specifics by the activities marked in the space provided.

- |                     |                          |                            |                         |
|---------------------|--------------------------|----------------------------|-------------------------|
| ____ Animals/pets   | ____ Discussions         | ____ Painting/Drawing      | ____ Singing            |
| ____ Bingo          | ____ Exercise/Walks      | ____ Playing an Instrument | ____ Sports             |
| ____ Cards          | ____ Fishing             | ____ Pool/Billiards        | ____ Traveling (where?) |
| ____ Children       | ____ Gardening           | ____ Puzzles               | ____ TV Shows/Movies    |
| ____ Cooking/Baking | ____ Golf                | ____ Reading               | ____ Word Games         |
| ____ Crafts         | ____ Music (type)        | ____ Quilting              |                         |
| ____ Dancing        | ____ News/Current Events |                            |                         |

**Other Skills or Talents:** \_\_\_\_\_

**D. Social/Financial Information:**

Social Services Receiving \_\_\_\_\_

Caseworker Name \_\_\_\_\_ Phone: \_\_\_\_\_

Church Affiliation \_\_\_\_\_

Organizations belonged to \_\_\_\_\_

Names and Locations of Children \_\_\_\_\_

\_\_\_\_\_

Names and Locations of Grandchildren \_\_\_\_\_

\_\_\_\_\_

Financial Assistance needed? Yes \_\_\_\_\_ No \_\_\_\_\_ Amount of Monthly Income \$ \_\_\_\_\_

**E. Registration Information:**

Planned days of attendance/week M T W TH F

Hours of attendance from: \_\_\_\_\_ To: \_\_\_\_\_

When do you want to start? \_\_\_\_\_

Transportation to Center by: Family \_\_\_\_\_ Other \_\_\_\_\_

**Waiver:** In case of illness or emergency, I give permission to Generations Crossing personnel to obtain qualified medical assistance, including: ambulance service, hospital, or physician, for the above named applicant.

Signature of person completing this application \_\_\_\_\_

Printed name of person signing \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Date: \_\_\_\_\_

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10/23/08

<b>Office use only:</b>	
Date of Interview: _____	Start of Care: _____
Date of Admission: _____	Date of Discharge: _____