ADULT DAY CARE CENTER
APPLICATION/ASSESMENT

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 # _____

Medicare # _____

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)

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 #

1._____

2._____

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

Therapy (Physical/Speech/Occupational): _____

In Home Care: _____

Office Use Only: ____DNR Status Reviewed ____Medication Policy Reviewed ____Change of Clothes Policy Reviewed

ACTIVITIES OF DAILY LIVING

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

_____ Bingo

_____ Cards

_____ Children

_____ Cooking/Baking

_____ Crafts

_____ Dancing

_____ Discussions

_____ Exercise/Walks

_____ Fishing

_____ Gardening

_____ Golf

_____ Music (type)

_____ News/Current Events

_____ Painting/Drawing

_____ Playing an Instrument

_____ Pool/Billiards

_____ Puzzles

_____ Reading

_____ Quilting

_____ Singing

_____ Sports

_____ Traveling (where?)

_____ TV Shows/Movies

_____ Word Games

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: _____

Reviewed with family by:
Employee signature: _____ Date: _____

Office use only:
Date of Interview: _____ Start of Care: _____

Date of Admission: _____ Date of Discharge: _____