ADULT DAY CARE CENTER APPLICATION/ASSESSMENT

Participant Information:

Full Name _____ Age _____ SSN _____-_____-_____

Preferred Name _____ Birth Date _____

Address _____

Phone _____ Birthplace _____

Present Living Situation _____

Marital Status S M W D Spouse _____ If widowed, when? _____

Medicaid ___ Yes ___ No Medicaid # _____

Medicare ___ Yes ___ No Medicare # _____

Long Term Care Insurance ___ Yes ___ No

If yes, specify _____

(Company Name and Policy Number)

Former Occupations _____

Education 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 or copy must be in the chart at Generations Crossing)

Caregiver Information:

Name of Caregiver(s) _____

Address _____

Phone (Home) _____ (Cell) _____

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. _____

Medical and Health Status:

Primary Diagnosis _____

_____

Additional Diagnoses _____

_____

Significant Medical History_____

_____

Medications _____

_____

Mental Status – Cognitive, Psychological, Intellectual & Emotional _____

_____

Behavioral Concerns or Substance Abuse _____

_____

Has the participant experienced any of the following behaviors?

Wandering ___ Yes ___ No Aggression ___ Yes ___ No Confusion ___ Yes ___ No

Nutritional Needs _____

_____

Allergies _____

Primary Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Hospital Preference _____ Date Last Admitted _____

Other Physicians Rendering Care

Name Type of Care Address Phone Number

1. _____

2. _____

Other Services Currently Receiving Needed in Day Care: (please give agency name and phone number)

Therapy (Physical/Speech/Occupational) _____

In Home Care _____

Social Services Receiving _____

Caseworker Name _____ Phone _____

Functional Condition:

Please check the appropriate box.

Activity	Needs Complete Assistance	Needs Some Help	Able To Do With Use of Device	Independent
Bathing				
Dressing				
Transferring				
Eating/Feeding				
Bowel				
Bladder				
Ambulation				
Wheeling				
Stair Climbing				
Mobility				
Meal Prep				
Housekeeping				
Laundry				
Money Management				
Transportation				
Shopping				
Using Phone				
Home Maintenance				

Communication Limitations _____

_____

Hobbies and Interests:

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

_____ Animal/Pets
_____ Bingo
_____ Cards
_____ Children
_____ Cooking/Baking
_____ Crafts
_____ Dancing
_____ Discussions
_____ Exercise/Walks
_____ Fishing
_____ Gardening
_____ Golf
_____ Music
_____ News/Current Events
_____ Painting/Drawing
_____ Playing an Instrument
_____ Pool/Billiards
_____ Puzzles
_____ Reading
_____ Quilting
_____ Singing
_____ Sports
_____ Traveling
_____ TV Shows/ Movies
_____ Word Games

Personal preferences that would enhance their experience at Generations Crossing: _____

_____

Social/Financial Information:

Names and Locations of Children _____

_____

Names and Locations of Grandchildren _____

_____

Additional Support to Help Provide Services/Care to Participant _____

_____

Church Affiliation/Organizations Belonged to _____

_____

Financial assistance needed? ___ Yes ___ No Amount of Monthly Income $_____

Registration Information:

Planned Days of Attendance/Week M T W Th F

Hours of Attendance From: _____ To: _____

When would you like 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 Application _____

Printed Name of Person Signing _____

Relationship to Applicant _____

Date _____

Reviewed with Family by:

_____ _____

Employee Signature Date