Blessed Assurance Adult Day and Health Care Services

Application for Enrollment

Applicant's full name: _____ DOB: _____ Sex: _____

Address: _____

Social Security #: _____ Medicaid #: _____

Medicare #: _____ SSI #: _____

Information about applicant

Why are you interested in your loved one coming to this program?

_____

Have they ever attended another adult day care program? _____

If yes, when, and where: _____

Marital status (circle): Married Single Separated Widowed Divorced

Current living arrangements (circle): With relatives With non-relatives With spouse

Alone in house/apartment Alone in a single room

Living with: _____ Relationship to participant: _____

Address: _____ Phone number: _____

Primary contact: _____ Address: _____

Phone number: _____ Employer & phone number: _____

Emergency Care Information

Please list the names and addresses of **at least two persons** who may be contacted in case of an emergency.

1. _____ _____ _____
   Name Relationship to participant Phone number

   _____ _____
   Address Email address

2. _____ _____ _____
   Name Relationship to participant Phone number

   _____ _____
   Address Email address

3. _____ _____ _____
   Name Relationship to participant Phone number

   _____ _____
   Address Email address

4. _____ _____ _____
   Name Relationship to participant Phone number

   _____ _____
   Address Email address

Physician Information

Physician: _____ Phone #: _____ Fax #: _____

Address: _____

Social Worker (if applicable): _____ Phone #: _____

Specialty Physician: _____ Phone #: _____ Fax #: _____

Address: _____

Transportation will be provided by: _____

Phone number: _____

Arrival time: _____Departure time: _____ Number & days a week applicant will be attending: _____

Is applicant on a special diet? _____ Food/drug allergies: _____

Supportive devices used by applicant (circle applicable): Wheelchair Walker Cane Hearing aids Dentures Eyeglasses

Please tell us anything that will help us better understand and enable us to provide your loved one with the best of care: _____

Please list any cultural, spiritual, or religious needs that we need to be aware of: _____

Applicant has a (circle what is applicable): Healthcare POA Living will DNR Order Durable POA

Name & telephone number of applicant's POA/guardian: _____

If you would like information on obtaining any of the mentioned above, please let us know.

It is a state requirement that all participants be tested for TB. This can be done at your loved one's doctor office, or here at Blessed Assurance. We charge a $25 fee, and your loved one will need to be back at this facility within 48 hours for the TB test to be read. If you would like for us to administer the TB test, please indicate here: ☐

Contract & Commitment

I understand that participation in this program will be paid by (circle): Myself_____

Another Party_____

Relative (Print name): _____ Daily cost is: _____

Telephone number of person responsible for payment: _____

If emergency medical care becomes necessary, I give permission for any treatment the physician deems necessary. My hospital of choice is _____, but I may be treated at the nearest facility.

Signature: _____

Print name: _____ Date: _____

Relationship if someone other than applicant signs this form: _____