Zellacare
Adult Day Care Service

Admissions Application

Applicant Information

Name: _____
Last *First* *Middle*

Address: _____
City *State* *Zip*

Phone: _____ Social Security#: _____ Sex: Male_____ Female_____

Age: _____ Date of Birth: _____ Birth Place: _____

Religion: _____ Married_____ Divorced_____ Separated_____
Single_____ Widowed_____ Domestic Partner _____

Primary Language: _____ Do you speak/understand English? Yes_____ No_____

Do you have: Medicaid: Yes_____ No_____ If Yes, Card#: _____

Medicare: Yes_____ No_____ If Yes, Card#: _____

Other Insurance: Yes_____ No _____ If Yes, Company: _____

Are you a Veteran? Yes_____ No_____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Address: _____
City *State* *Zip*

Phone#: (Day):_____ (Evening):_____

Work #:_____ Ext: _____

CHILDREN/OTHER INTERESTED PARTIES:

Name: _____ Relationship: _____

Address: _____
City *State* *Zip*

Phone#: (Day):_____ (Evening):_____

Work #:_____ Ext: _____

Name: _____ Relationship: _____

Address: _____

City *State* *Zip*

Phone#: (Day):_____ (Evening):_____

Work #:_____ Ext: _____

PERSONAL PHYSICIAN/CLINIC: _____ CLINIC ID#: _____

Address: _____

City *State* *Zip*

Phone#: _____ Fax: _____

ARE YOU ENROLLED IN ANY LONGTERM CARE PROGRAM OR VNS AT THE PRESENT TIME? Yes_____ No_____

WHY DID YOU SEEK ADMISSION TO THE ADULT CARE PROGRAM? _____

_____

_____

_____

_____

MEDICAL INFORMATION

Primary Physician: _____ Telephone: _____

Address: _____

City *State* *Zip*

Medical Coverage: _____ Number: _____

Medical History

Primary diagnosis: _____

Mental Illness: _____ Substance Abuse: _____

Other medical diagnosis: _____

Check all that apply

Hearing Impaired_____ Hearing Aide_____ Visually Impaired_____ Glasses_____ Cane_____

Walker_____ Wheelchair_____ Prosthesis_____ Dentures_____ Other: (please explain):_____

List any other agencies caring for the client: _____

Home Delivered Meals: Contact Person _____Telephone#_____

Does the client have a Power of Attorney or Legal Guardian? Yes____ No ____

Copy on file and contract? Yes____ No____

Referral Source _____

Applicant Signature_____ Date_____

Signature of Person Completing Form_____ Relationship_____

MEDICATIONS

MEDICAL PROBLEMS	MEDICATION	DOSAGES	FREQUENCY