

GENERATIONS ADULT DAY HEALTH CENTER

PARTICIPANT APPLICATION FORM

Instructions for completing form: Circle Yes or No and answer all questions

NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY NUMBER: ____/____/____ EMAIL: _____

GROUP HOME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (____) _____ CELL PHONE: (____) _____

INSURANCE: _____

PRIMARY CARE PHYSICIAN: _____ TELEPHONE: (____) _____

OTHER PHYSICIAN: _____ TELEPHONE: (____) _____

YOUR DIAGNOSIS: _____

FOOD ALLERGIES? YES or NO; IF YES, WHAT? _____

DRUG ALLERGIES? YES or NO; IF YES, WHAT? _____

HAVE YOU EVER BEEN CHARGED WITH A FELONY? YES or NO. IF YES, PLEASE EXPLAIN IN DETAIL: _____

LIST ANY ILLNESSES FOR WHICH YOU ARE RECEIVING TREATMENT _____

IF ACCEPTED AS A PARTICIPANT, WOULD YOU REQUIRE TRANSPORTATION TO AND FROM GENERATIONS? YES OR NO?

GENERATIONS ADULT DAY HEALTH CENTER

BRIEFLY STATE WHAT YOU HOPE TO GET FROM GENERATIONS ADULT DAY HEALTH PROGRAM: _____

PLEASE LIST BELOW UP TO THREE EMERGENCY CONTACTS, AND CASE MANAGER CONTACT, IF APPLICABLE:

NAME: _____ TELEPHONE: () _____

RELATIONS TO YOU: _____

NAME: _____ TELEPHONE: () _____

RELATIONS TO YOU: _____

NAME: _____ TELEPHONE: () _____

RELATIONS TO YOU: _____

CASE MANAGER NAME: _____

AGENCY: _____ TELEPHONE: () _____

PLEASE ATTACH A LIST OF YOUR CURRENT MEDICATIONS, INCLUDING OVER- THE-COUNTER MEDICATIONS.

PLEASE SIGN AND DATE BELOW. Note that if a person other than the applicant is signing for the applicant, that person should specify the relationship to the applicant in the space provided below the signature/date line.

If the signatory is the applicant's legal representative, including but not limited to a court appointed Guardian, then documentation related to the appointment must be provided before this application can be processed.

NAME: _____ DATE _____

RELATIONSHIP TO APPLICANT: _____

In order to continue the application process, be sure to:

(a) forward this application form to Generations Adult Day Health Center

(b) forward the medical form to your primary care physician and the psychiatric form, if applicable, to your psychiatrist.