Generations
Comprehensive Health & Rehabilitative Services

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?

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.