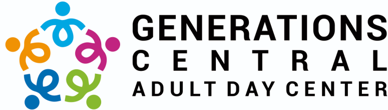


Enrollment Application

Name ___________________________Date of Birth ____/____/____ Age______Gender_______

Street Address _______________________________________ PO Box _______ Apt # ________

City ____ State _________ Zip Code ____________

Phone # -Home (_______)________________________Cell #(_______)_____________________

Email Address:________________________________ Highest Level of Education_____________

Advance Directive

Do you have an Advance Directive? Circle: Yes or No If yes, attach copy.

DNR (Do Not Resuscitate) Order? Circle: Yes or No If yes, attach copy.

Responsible Party

Name of Responsible Party/Caregiver ____

List Power of Attorney (same?) ____

(Attach documentation of power of attorney)

Relationship to Applicant ____

Street Address ____ PO Box _______ Apt # _____

City ____State: ________ Zip ____________

If employed, where? ____

Phone # ______________________________ Cell Phone # _____________________________

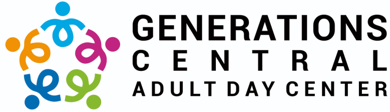
Physician Information

Primary care physician _____________________________ Phone # __________________

Address ____

Treatment for ____

Prescribes which medications? ____



Other physicians providing care and why:

Name ____ Phone # ___________

Address ____

Treatment for ____

Prescribes which medications? ___________________________________

Name ____ Phone # ___________

Address ____

Treatment for ____

Prescribes which medications? ___________________________________

Dentist ______________________________________ Phone # ___________

Address ____

Agencies providing care, including area agency on aging, home health, etc:

Agency Name _______________________ Service Provided ____________________

Start Date ______________________ _________________________________

Agency Name _______________________ Service Provided ____________________

Start Date ______________________ _________________________________

_____________________________________ _____________________________

(Signature of Responsible Party) *(Date)*