GENERATIONS CENTRAL ADULT DAY CENTER

Enrollment Application

Name _____Date of Birth ____/____/____ Age_____Gender_____

Street Address _____ PO Box _____ Apt # _____

City _____ State _____ Zip Code _____

Phone # -Home (_____)_____ Highest Level of Education_____

Responsible Party

Name of Responsible Party/ Primary Caregiver _____

Street Address _____ PO Box _____ Apt # _____

City _____State: _____ Zip _____

Primary Phone # _____ Secondary Phone # _____

Email _____

Additional Emergency Contacts

Name _____ Relationship to Participant _____

Street Address _____ PO Box _____ Apt # _____

City _____State: _____ Zip _____

Primary Phone # _____ Secondary Phone # _____

Check if authorized to pick up the participant from the Center _____

Name _____ Relationship to Participant _____

Street Address _____ PO Box _____ Apt # _____

City _____State: _____ Zip _____

Primary Phone # _____ Secondary Phone # _____

Check if authorized to pick up the participant from the Center _____

Income Verification

Participant's Monthly Income_____ Spouse's Monthly Income (if applicable) _____

Check if you would like us to screen you for a sliding scale fee _____

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Physician Information

Primary care physician _____ Phone # _____

Address _____

Treatment for _____

Prescribes which medications? _____

Other physicians or Services providing care and why:

Name _____ Phone # _____

Address _____

Treatment for _____

Name _____ Phone # _____

Address _____

Treatment for _____

Advance Directive/Emergency Care

Does the participant have a DNR (Do Not Resuscitate) Order? Yes____ No ____

(If DNR order is in effect, an original or copy must be in the chart at Generations Central)

List Power of Attorney _____*(Please attach a copy of POA)*

Hospital Preference _____

WAIVER: In the event of injury, illness or other emergency, I understand that Generations Central Adult Day Center will seek medical assistance from a qualified service, physician, and/or hospital.

Signature of Participant or Power of Attorney _____ Date _____

Participant History

Former Occupations_____

Education Level Completed _____ Ability to Read ___ Yes ___ No

Veteran ___ Yes ___ No War _____ Branch of Service _____

Any Personal preferences that would enhance their experience at Generations Central

_____

_____

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Hobbies/Interests

Please place an X next to the activities the participant currently does or may have interest in while here at the Center. Provide additional information in the comments.

_____ Animal/Pet Visits

_____ Discussion Groups

_____ Painting/Drawing

_____ Singing

_____ Exercise/Walks

_____ Table Games

_____ Cards

_____ Chapel

_____ Active Games (i.e. Corn Hole, Ring Toss, Bowling)

_____ Traveling

_____ Children

_____ Gardening

_____ Puzzles

_____ TV Shows

_____ Cooking/Baking

_____ Reading

_____ Crafts

_____ Music

_____ Quilting

_____ Word Games

_____ Dancing

_____ News/Current Events

Comments _____

_____

_____

Registration Information

We are open Monday-Friday from 8am-4pm. Your participant can attend Full-Days or Half-Days (4 hours or less) based on your needs. We required participants to attend a minimum of one Full-Day or two Half-Days per week.

Planned Days of Attendance/Week (Circle) M T W Th F

(Circle) Half-Days Full Days

When would you like to start? _____

Transportation to Center by: Family _____ Other _____

Please list three days/times in the next week that our Nurse Coordinator can contact you via phone to complete your assessment: _____

_____ _____

(Signature of Participant or Legally Authorized Representative) *(Date)*