HEBREW SENIOR CARE ADULT DAY CENTER
1 ABRAHMS BLVD.
W. HARTFORD, CT 06117
Phone: (860) 523-3857
Fax: (860) 523-3989

APPLICATION FOR ADMISSION TO SENIOR DAY CENTER
EMERGENCY MEDICAL INFORMATION

Date:__________________________ Admission Date:_______________

Applicant's Name: ____

Address: ____

Home Phone Number: _____________________________________

Likes to be called by (nickname) ____

Date of Birth: __________________________ Place of Birth: _____________________

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____

Is client a veteran __________________ Branch of Service ____________________

With whom does the applicant live? ____

Who is the primary caregiver for client? _____________________________________

Who will be responsible for the bill? Private pay/client ____Private pay/family____

CCCI_____ Insurance_____ VA _____ Monthly Income _________________

How did you hear about us?__________________________________

Responsible Party

Name ___________________________________ Relationship ____________________

Address ____

Phone (H) ___________________ Cell______________________

Phone (wk) ___________________ E-mail___________________

Other Emergency Contacts

	Name	Relationship	Home Phone	Work	Cell
1.					
2.					

PHYSICIAN (Primary)

______________________________PHONE________________FAX______________

PHYSICIAN PHONE FAX ______

PHYSICIAN PHONE FAX

CHOICE OF HOSPITAL RELIGION ______

LAST 4 DIGITS OF SS# MEDICARE NO. ______

TITLE XIX NO/MEDICAID NO HOME CARE AGENCY________

CCCI CLIENT # FUND# __________ _

LIVING WILL **YES____(Please provide a copy for our records) NO)____**

Please list all pertinent Medical History:

____

____

____

____

ALLERGY: ____

Please list ALL medications client is on:

____

____

____

____

____

____

Diet: Regular_______Low Sodium_________Diabetic_________Other___________

Background

Level of Education ___________Languages spoken___________________________

Former occupation___________________________

Other skills____

Siblings___________________

Interests:
What are your hopes, dreams or desires?____

Art_____**Crafts**_____**Cooking**_____**Carpentry**_____**Games**_____**Music**_____
Instrument Played ___________________________

Pets_____ **Sports**_____ **Travel** _____ **Reading**_____ **Hobbies**_____ **Gardening**_____
Other_________________________________

Volunteer service of social clubs _________________**Socially active** ________________

Prefers group or individual activity ________________

Comments:

____

<u>Activities of Daily Living</u>

Continence: Bowel: Always _______ Usually _______ Never ______

Bladder: Always ______ Usually _______ Never ________

Toileting: Independent _______________ Requires Assistance _______________

Does the applicant need help with: Eating ___ bathing ___ Dressing ___Transfers ___

Hand Dominance __________________

<u>Please check if client has any of the following:</u>

Glasses ___ Cane ___ Pacemaker ___ Contacts ___ Walker ___Internal Defibrillator ___

Dentures ___ Wheelchair ___ Hearing Aid L ___ R ___ Brace ___

<u>Personal</u>

Alcohol: No ___ Yes ___ Type __________________ How Often _____________

Tobacco: Cigarettes ___ Pipe ___ Cigar ___ How much __________

<u>Your Children</u> (If different from emergency contacts

Home Phone ______________ **Work** ________________ **Cell**____________

____
____
____

Date you would like to start: ______________________

Frequency of days attending: ___________________

Days: M ______ **T** ______ **W** ______ **TH** ______ **F** ______

Transported by: Family________________ **SDC** _______________________

What special needs does the applicant have?

(Ex. Need for socialization, supervision, etc)

____

Person completing this form: ____

Date: ________________________________

Hebrew Senior Care Adult Day Center

Client's Waiver for Services

Bill of Rights

Acknowledgement and General Consent

Name of Client: ____

Name of Responsible Party (if applicable) ____________________________________

I. **Acknowledge that I have received the Hebrew Adult Day Center Admission/Discharge/Emergency Care Policy.**

II. **Have Received the Hebrew Senior Care ADC client's Bill of Rights and Responsibilities, grievance procedures and the complaint policy.**

III. **Have received the Notice of Privacy Information Practices.**

IV. **(DO, DO NOT) give permission to the Adult Day Center to use my name, take photographs, motion pictures and/or sound recording of me. I understand that these may be used in publicity or publication concerning Hebrew Senior Care and its services/operations.**

V. **Authorize Hebrew Senior Care ADC to transport me off the premises for trips, outings, recreational or educational programs selected and supervised by day center staff.**

VI. **Acknowledge that I have received the Adult Day Center medication policy.**

VII. **Hereby authorize the Adult Day Center to release or receive from hospitals, physicians, lawyers and/or other social, professional and institutional agencies involved in my care, all medical records and information pertinent to my care. I hereby give permission for the review of my medical records by accrediting agencies or regulatory bodies and to release information about me and/or my family to individuals involved in my care. I understand that I may withdraw this authorization at any time, but such withdrawal must be in writing, signed by myself or family member. Information released prior to any written withdrawal of authorization will continue to be covered under the original authorization.**

VIII. I agree to pay for the service of Hebrew Senior Care Adult Day Center at a rate of _______________ a day for as many days as the participant attends the program. I agree to pay on a monthly basis and to send this payment within seven days after receiving the monthly statement. Checks are made payable to Hebrew Senior Care Adult Day Center. I understand that if I do not pay within 30 days of receipt of invoice a late charge will apply. Overdue accounts are subject to a late charge. I agree to notify the Adult Day Center on any day that I am unable to attend. I understand that I will not be billed for days that I am absent from the program due to sickness, etc. If absenteeism becomes excessive, this policy will be re-evaluated with each participant. I understand that I can increase/decrease the days I attend the program by making arrangements with the Adult Day Center at least two weeks in advance.

IX. Person/Payer source to be billed

____

Your signature on this form will be your acknowledgement that you have received and understood all the information as stated on this form.

____ _______________

Signature of Client or Responsible Party Date