THE CARING PLACE ADULT DAY CARE CENTER
APPLICATION FOR ENROLLMENT

PARTICIPANT INFORMATION Enrollment Date: _____

Participant Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: M __ F __

Telephone Number: _____ Date of Birth: _____ Age: _____

Email Address: _____

Medical Insurance Provider: _____

Policy Number: _____ Group Number: _____

Does the Participant have a Court Appointed Guardian? N ___ Y ___

Name: _____ Phone Number: _____

CAREGIVER INFORMATION

Caregiver Name: _____ Relationship: _____

Address (if different): _____

City: _____ State: _____ Zip: _____

Telephone (Day): _____ Telephone (Night): _____

ADULT DAYCARE SERVICES: (CHECK PREFERRED SERVICE)

___ Two Days Per Week ___ M and W ___ Tu and Th - 9:00 a.m. – 3:00 p.m. – Weekly Total Cost $144.00

___ Four Days Per Week M – Th 9:00 a.m. – 3:00 p.m. – Weekly Total Cost $288.00

Payment Options:

___ Autodraft from bank account weekly on Friday of each week OR

___ Charged to credit card weekly on Friday of each week OR

Note: Autodraft will be from your credit card or bank account according to the information provided. If paid by credit card.

Source of Payment Options: (check all that apply)

___ Private Pay ___ Medicaid: Medicaid ID Number: _____

___ I am eligible to receive Medicaid benefits and have already been approved.

___ I do not know if I am eligible for Medicaid benefits and need assistance in making an application.

___ I understand that if I am eligible for Medicaid benefits, I would not be eligible for a Caring Place scholarship, should there be available funds.

___ I am interested in obtaining information for annual and semi-annual grants from Area Agency on Aging and Arkansas Alzheimer's Association for assistance with payment of my services obtained at the Caring Place.

PARTICIPANT HEALTH INFORMATION (CHECK APPLICABLE BLANKS)

Dementia Diagnosis: ___ Alzheimer's ___Stroke ___Parkinson's ___ Unknown

Other: _____

Is the participant aware of the diagnosis? ___ Yes ___ No

Primary Physician(s): 1. Name _____

Address _____

Telephone _____

2. Name _____

Address _____

Telephone _____

3. Name _____

Address _____

Telephone _____

Date of last medical evaluation: _____

Overall Rating of Physical Health at Present: ___ Excellent ___ Good ___ Fair ___ Poor

Special Health Conditions (Please check all that apply):

___ Seizures ___ Problems Swallowing ___ Heart Problems

___ Diabetes ___ History of Falling ___ Stroke

___ Osteoarthritis ___ Osteoporosis ___ Blood Pressure ___ High ___ Low

Past Surgeries (please use separate page if necessary): _____

_____

_____

_____

Other (Please specify): _____

_____

_____

_____

Diet Consistency: ___ Regular ___ Soft ___ Chopped ___ Pureed

Special Equipment Used: ___ Hearing Aid ___ Glasses ___ Walker

___ Dentures: ___ Upper ___ Lower ___ Cane ___ Eating Utensils ___ None

Allergies: ___ No Known Allergies

___ Medication Allergies: _____

___ Food Allergies: _____

___ Environmental Allergies: _____

Toileting Habits (Check all that apply):

___ Independent ___ Independent with Pads ___ Needs Reminders

___ Needs Assistance ___ Lacks Bladder Control ___ Lacks Bowel Control

___ Behavioral Problems Related to Toileting

Please describe routing for toileting (i.e., how often, times of day, type of assistance needed):

_____

_____

_____

Behaviors Exhibited by Participant (Check all that apply):

___ Agitated ___ Cooperative ___ Physically Aggressive ___ Sociable

___ Wandering ___ Withdrawn ___ Verbally Aggressive ___ Worse in the Evening

Explain:

_____

_____

PARTICIPANT SOCIAL INFORMATION

The following information will assist us in encouraging the participant to maximize his/her abilities, socialization, and self-esteem.

Languages Spoken (past or present): _____

Former Occupation: _____

Club Memberships (past or present): _____

How does the participant usually spend an average day? _____

_____

Interest past and present (Check all that apply):

___ Reading ___ Radio ___Music ___ Singing ___ Games ___ Sports

___Lectures ___ Gardening ___ Crafts ___ Movies ___ Sewing ___ Handiwork

___ Church ___ Concerts ___ Cooking ___ Exercise ___ Outings ___ Conversation

___ Walking ___ Grooming ___ Pets ___ Collector ___ Travel ___ Woodworking

Housing: ___ Apartment ___ Home ___ Retirement Home ___ Assisted Living Facility

___ Foster Care Facility ___ Other: _____

Living Situation: ___ Lives Alone ___ Lives with Spouse ___ Lives with Adult Child

___ Lives with Other Relative ___ Lives with non-Relative ___ Lives with Hired Caregiver

Ethnicity: ___ American Indian or Native American ___ Hispanic ___ Asian/Pacific Islander

___ Black, non-Hispanic ___ Caucasian, non-Hispanic ___ Declined to Respond

___ Other: _____

Religion: _____

Highest Educational Level Achieved: ___ Grammar School ___ GED ___ High School/Vocation

___ College ___ Graduate School

Annual Household Income: ___ Less than $10,000 ___ $10,000 - $20,000

___ $20,000 - $40,000 ___ More than $40,000

RESPONSIBLE PARTY / SPOUSE INFORMATION

Name of Spouse or Nearest Relative: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Participant: _____ Telephone: _____

Email Address: _____

Person Responsible for Payment: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Participant: _____ Telephone: _____

Email Address: _____

Occupation / Employer: _____

If Self Employed, Name of Business: _____

Address of Business: _____

I understand this information is confidential and will not be released to any other person without written permission.

Signature of Participant / Responsible Party: _____

Date: _____