Enrollment Date: _____

Edwards Adult Day Center
Application for Enrollment

Full Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Social Security # xxx-xx-_____

Address: _____

_____

Phone: _____ Marital Status: _____ Spouse's name: _____

Children's Names Address Phone #

_____

_____

_____

Primary Caregiver: (this is the main contact with whom the center will communicate)

_____ Relationship: _____

Address if different from participant: _____

_____

TWO people who may be contacted in case of emergency: (two persons are required by licensing standards)

Name (relationship): _____ Phone: _____

Name (relationship): _____ Phone: _____

A copy of the following information must be provided prior to enrollment if applicable

POWER OF ATTORNEY? YES NO If yes, who? _____
DNR (do not resuscitate?) YES NO If yes, yellow copy needs to be provided.
Advanced Directive YES NO

*****Provide a copy of **ALL** current insurance cards. □ Medicare □ Medicaid □ Private Insurance

Primary Care Physician: _____ Phone #: _____

Pay Source: Private Veteran's Administration Medicaid #_____

Planned attendance (please circle): Monday Tuesday Wednesday Thursday Friday

Planned Transportation to the center: ADC van Family/other

_____ _____

Signature of person completing application Date

The following information is optional. However, the more we know about a participant the more we can interact and develop programs to maintain and improve functioning.

Mobility:
- ☐ Ambulatory
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair

Communication:
- ☐ Speaks Clearly
- ☐ Slow speech
- ☐ Speech aphasia (distorted)
- ☐ Non-verbal

Eyesight:
- ☐ Adequate, no correction needed
- ☐ Glasses
- ☐ Eye disease

Auditory:
- ☐ Adequate
- ☐ Hard of Hearing
- ☐ Hearing Aids? Left Right

Eating:
- ☐ Feeds self **OR**
- ☐ Needs assistance
- ☐ Eats well **OR**
- ☐ Eats poorly
- ☐ Dentures?

Motor Skills:
- ☐ Right Handed
- ☐ Left Handed
- ☐ Good Control
- ☐ Poor Control

Hygiene:
- ☐ Independent
- ☐ Needs Assistance

Toileting:
- ☐ Continent
- ☐ Incontinent
  - ☐ Bowel
  - ☐ Bladder

Sleep Pattern:
- ☐ Needs Nap
- ☐ No Nap Encouraged

Mental State:
- ☐ Alert and Oriented
- ☐ Alert but confused at times
- ☐ Hallucinations at times
- ☐ Depressed
- ☐ Withdrawn
- ☐ Wanderer
- ☐ Aggressive
- ☐ Socializes Readily

- Will medications be administered by the center? YES NO
- Does the participant have a pacemaker, defibrillator or any other medical device which the staff should be aware? _____
- List any hobbies or interests the participant may have or has had in the past: _____

  _____
- List any church membership or pastor the participant prefers _____

  _____
- List any military service, occupations, jobs, clubs or civic organizations the participant has served

  _____
- List any **Allergies**, special considerations or needs: _____

  _____

  _____