Samaritan
Keep Home

Adult Day Health Care Application

☐ Social Model ☐ Medical Model

Personal Information:
Applicant's Full Name: _____ **Date of Birth:** _____
Social Security Number: _____ **VA Status:** _____

Marital Status: (Circle one)
Single Married Divorced Widowed Legally Separated

Current Address: _____
County:
Home Phone Number: _____ **Attending Physician:** _____
Present Location _____ **Community Physician:** _____

Advance Directives: (Circle All that Apply)

HCP	**Living Will**	**Organ Donor**
POA	**DNR**	**MOLST**

Health Insurance Coverage: (Provide copies of cards for all that apply)

Self Pay: Yes No	
Medicare	**Part A: Yes No Part B: Yes No** **Medicare#:** _____
Medicaid **Community** _____ **Long Term Care** _____	**Yes No Applying Date:** _____ **County:** _____ **Case Worker:** _____ **Medicaid#:** _____ **Effective Date:** _____

Emergency Contacts:

	Primary	Secondary
Name:		
Address:		
Relationship:		
Home Phone:		
Work Phone:		
Cell Phone:		
Email Address:		
Power Of Attorney:		
Health Care Proxy:		

Person Responsible for Management of Resident's Financial Affairs:

_____

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List Recent Hospitalizations:

Hospital	Admission Date	Discharge Date

Medical Problems: _____ _____

_____ _____

_____ _____

Current Medications:

Name	Dose	Amount	Time

Do you have any current allergies? **Yes** **No**

If yes, to what? _____

Are you on a special diet? **Yes** **No**

If yes, please explain: _____

When was your last dental examination? _____

When was your last eye examination? _____

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Do you have?:

Dentures _____
Partial Plate _____
Missing Teeth _____

Do you have the following:			**Are you seen by the following:**		
Brace	**Yes**	**No**	**Social Worker**	**Yes**	**No**
Cane	**Yes**	**No**	**Occupational Therapist**	**Yes**	**No**
Walker	**Yes**	**No**	**Physical Therapist**	**Yes**	**No**
Artificial Limb	**Yes**	**No**	**Speech Therapist**	**Yes**	**No**
Wheelchair	**Yes**	**No**			
Glasses	**Yes**	**No**			
Hearing Aide	**Yes**	**No**			

Can applicant be left alone at home? **Yes** **No**

Previous Occupation _____

How do you occupy your free time? _____

_____

_____

Have you noticed a change in your memory, if so, does it interfere with your daily activities?

Yes **No**

Please check the level of assistance for the following daily activities:

	Independent	**Intermittent**	**Constant**
Bathing	_____	_____	_____
Personal Care	_____	_____	_____
Dressing	_____	_____	_____
Walking	_____	_____	_____
Transferring	_____	_____	_____
Stairs	_____	_____	_____
Toileting	_____	_____	_____
Eating	_____	_____	_____
Housekeeping	_____	_____	_____
Bill Paying	_____	_____	_____
Laundry	_____	_____	_____
Appointments	_____	_____	_____
Shopping	_____	_____	_____
Telephone	_____	_____	_____
Cooking	_____	_____	_____

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Who referred you to this program? _____

Will you need transportation by the Samaritan Keep Home?	**Yes**	**No**
If wheelchair bound, is your home accessible by a wheelchair ramp?	**Yes**	**No**

Directions to your residence:

_____

_____

_____

Comment:

*** Effective November 15, 2007, all Samaritan Health Facilities are now tobacco free. Individuals are not to be permitted to smoke on grounds. Electronic cigarettes are also prohibited on facility grounds.**

I acknowledge that all Samaritan Health Facilities are tobacco free.

_____ **Resident/Designate Representative**

According to my knowledge and belief, the foregoing information is complete, accurate, and true in all respects.

_____ _____

Signature of Applicant/ Representative (REQUIRED) **Date**

***New York State and Federal Laws prohibit discrimination in any form on the basis of Race, Creed, Color, National Origin, Sex, Handicap, or Source of Payment in any program or activity receiving any assistance or support from public money."**