



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
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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:

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? _____

Do you have?:

 Dentures _____
 Partial Plate _____
 Missing Teeth _____

Do you have the following:

Brace	Yes	No
Cane	Yes	No
Walker	Yes	No
Artificial Limb	Yes	No
Wheelchair	Yes	No
Glasses	Yes	No
Hearing Aide	Yes	No

Are you seen by the following:

Social Worker	Yes	No
Occupational Therapist	Yes	No
Physical Therapist	Yes	No
Speech Therapist	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
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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	_____	_____	_____



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."