

Hebrew Senior Care Senior Day Center

an affiliate of Hebrew Senior Care Inc.

Application

Date/Time: _____ MR #: _____ Admission Date: _____

Client Name: _____
Last First (Nickname)

Date of Birth: _____

Preferred Name: _____ Male _____ Female _____

Address: _____ Tel#: _____

Veteran: _____ Religion _____ Marital Status: _____

U.S. Citizen _____ Race _____ Type of Housing: _____

No. of Persons in Household: _____

Caller's Name: _____ Relationship to client: _____

Tel#: _____ Reason for Referrals: _____

Address: _____

Referral Source: _____ Note Sent: _____

Email Adress: _____

1. Emergency Contact: _____ Relationship: _____

Address: _____ Tel#:(H) _____

2. Emergency Contact: _____ Relationship: _____

Address: _____ Tel#:(H) _____

Tel#:(W) _____

Power of Attorney: _____
Name Address Tele# Relationship

Primary Physician: _____ Tel#: _____ FAX: _____

Address: _____ Medicals Sent: _____

Physician: _____ Tel#: _____

Address: _____ Hospital of Choice: _____

Medicare#: _____ Medicaid#: _____

Social Security#: _____ Other Insurance#: _____

Pharmacy: _____ Other Agencies#: _____

Clients Mentation: _____ Ambulatory Status: _____

Code Status: _____ Advanced Directive: _____

FEE AGREEMENT

Service Requested:

Adult Day Center/Days Requested: _____ Days Avail.: _____

Previous Day Center experience _____

Transportation: _____ Special Needs: _____

Fee Assessed: _____ Additional Funding Sources: _____

Case Manager: _____

Bill to: _____

Client/ Responsible Party/ Date

Staff Signature/Date

