Hebrew HealthCare Senior Day Center

an affiliate of Hebrew Healthcare, Inc.

Application

Date/Time:______________________________________ MR #:____________ Admission Date:_____________

Client Name:______________________________________ Date of Birth:_________________________________
Last First (Nickname)

Preferred Name:________________________________ Male_____ Female______

Address:____ Tel#:____

____ Marital Status:__________________________________

Veteran:_________________Religion______________ Type of Housing:_________________________________

U.S. Citizen_____________Race__________________ 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)_______________________________________
   __________________________________ Tel#:(W)_______________________________________
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/DaysRequested:_____________________________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

____ ____

NOTES

DIRECTIONS

REV: 9/00, 9/01, 05/02, 10/04, 7/11, 10/13, 07/15, 06/16