HEBREW SENIOR CARE SENIOR DAY CENTER
1 ABRAHMS BLVD.
W. HARTFORD, CT 06117
Phone: (860) 523-3857
Fax: (860) 523-3989

APPLICATION FOR ADMISSION TO SENIOR DAY CENTER
EMERGENCY MEDICAL INFORMATION

Date: ________________________ **Admission Date:** ______________

Applicant's Name: ____

Address: ____

Home Phone Number: __________________________________

Likes to be called by (nickname) ____

Date of Birth: ________________________ **Place of Birth:** __________________

Marital Status: Married _____ **Single** _____ **Widowed** _____ **Divorced** _____

Is client a veteran _________________ **Branch of Service** ___________________

With whom does the applicant live? ______________________________________

Who is the primary caregiver for client? ___________________________________

Who will be responsible for the bill? Private pay/client ____**Private pay/family**____

CCCI_____ **Insurance**_____ **VA** _____ **Monthly Income** ________________

How did you hear about us?________________________________

Responsible Party

Name ________________________________ **Relationship** ___________________

Address ____

Phone (H) __________________ **Cell**____________________

Phone (wk) __________________ **E-mail**__________________

Other Emergency Contacts

	Name	Relationship	Home Phone	Work	Cell
1.					
2.					

PHYSICIAN (Primary)

_______________ PHONE _______________ FAX _______________

PHYSICIAN _______________ PHONE _______________ FAX _______________

PHYSICIAN _______________ PHONE _______________ FAX _______________

CHOICE OF HOSPITAL _______________ RELIGION _______________

LAST 4 DIGITS OF SS# _______________ MEDICARE NO. _______________

TITLE XIX NO/MEDICAID NO _______________ HOME CARE AGENCY _______________

CCCI CLIENT # _______________ FUND# _______________

LIVING WILL YES____(Please provide a copy for our records) NO)____

Please list all pertinent Medical History:

____

____

____

____

ALLERGY: ____

Please list ALL medications client is on:

____

____

____

____

____

____

Diet: Regular_______Low Sodium_________Diabetic_________Other___________

Background

Level of Education ___________Languages spoken____________________________

Former occupation____________________________

Other skills____

Siblings____________________

Interests:
What are your hopes, dreams or desires?________________________________

Art_____Crafts_____Cooking_____Carpentry_____Games_____Music_____
Instrument Played ________________________

Pets_____ Sports_____ Travel _____ Reading_____ Hobbies_____ Gardening_____
Other______________________________

Volunteer service of social clubs _______________**Socially active** ______________

Prefers group or individual activity ______________

Comments:

____

Activities of Daily Living

Continence: Bowel: Always _______ Usually _______ Never ______

Bladder: Always ______ Usually _______ Never ________

Toileting: Independent ______________ Requires Assistance ______________

Does the applicant need help with: Eating ___ bathing ___ Dressing ___Transfers ___

Hand Dominance _________________

Please check if client has any of the following:

Glasses ___ Cane ___ Pacemaker ___ Contacts ___ Walker ___Internal Defibrillator ___

Dentures ___ Wheelchair ___ Hearing Aid L ___ R ___ Brace ___

Personal

Alcohol: No ___ Yes ___ Type _________________ How Often ____________

Tobacco: Cigarettes ___ Pipe ___ Cigar ___ How much __________

Your Children **(If different from emergency contacts**

Home Phone _____________ **Work** _______________ **Cell**___________

____

____

____

Date you would like to start: ____________________

Frequency of days attending: __________________

Days: M _____ **T** _____ **W** _____ **TH** _____ **F** _____

Transported by: Family_______________ **SDC** ____________________

What special needs does the applicant have?

(Ex. Need for socialization, supervision, etc)

____

Person completing this form: ____

Date: ______________________________