Please fill out the Senior Day Center Application and save it to your computer. Once saved please email the application to csmith@hebrewseniorcare.org.

HEBREW SENIOR CARE ADULT 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: _____

Hebrew Senior Care Adult Day Center

Client's Waiver for Services

Bill of Rights

Acknowledgement and General Consent

Name of Client: _____

Name of Responsible Party (if applicable) _____

I. Acknowledge that I have received the Hebrew Adult Day Center Admission/Discharge/Emergency Care Policy.

II. Have Received the Hebrew Senior Care ADC client's Bill of Rights and Responsibilities, grievance procedures and the complaint policy.

III. Have received the Notice of Privacy Information Practices.

IV. (DO, DO NOT) give permission to the Adult Day Center to use my name, take photographs, motion pictures and/or sound recording of me. I understand that these may be used in publicity or publication concerning Hebrew Senior Care and its services/operations.

V. Authorize Hebrew Senior Care ADC to transport me off the premises for trips, outings, recreational or educational programs selected and supervised by day center staff.

VI. Acknowledge that I have received the Adult Day Center medication policy.

VII. Hereby authorize the Adult Day Center to release or receive from hospitals, physicians, lawyers and/or other social, professional and institutional agencies involved in my care, all medical records and information pertinent to my care. I hereby give permission for the review of my medical records by accrediting agencies or regulatory bodies and to release information about me and/or my family to individuals involved in my care. I understand that I may withdraw this authorization at any time, but such withdrawal must be in writing, signed by myself or family member. Information released prior to any written withdrawal of authorization will continue to be covered under the original authorization.

VIII. I agree to pay for the service of Hebrew Senior Care Adult Day Center at a rate of _____ a day for as many days as the participant attends the program. I agree to pay on a monthly basis and to send this payment within seven days after receiving the monthly statement. Checks are made payable to Hebrew Senior Care Adult Day Center. I understand that if I do not pay within 30 days of receipt of invoice a late charge will apply. Overdue accounts are subject to a late charge. I agree to notify the Adult Day Center on any day that I am unable to attend. I understand that I will not be billed for days that I am absent from the program due to sickness, etc. If absenteeism becomes excessive, this policy will be re-evaluated with each participant. I understand that I can increase/decrease the days I attend the program by making arrangements with the Adult Day Center at least two weeks in advance.

IX. Person/Payer source to be billed

_____

Your signature on this form will be your acknowledgement that you have received and understood all the information as stated on this form.

_____ _____

Signature of Client or Responsible Party Date