Community Action Agency

Dunbar Intergenerational Adult Day Health

New Client Application

Client Name:_____ DOB:_____

Address:_____

City:_____State:_____Zip Code:_____

Referred By:_____

Marital Status:_____Lives With:_____

SSN:_____Medicare Number:_____Medicaid Number:_____

Reason for Applying to Adult Day Health:_____

_____

Primary Care Providers:_____Psychiatrist/ Counselor:_____

Hospital Choice:_____ Pharmacy Choice and Number:_____

Allergies: _____

Diagnosis: _____

_____

Functional Limitations: _____

_____

Dentures: Y☐ N ☐ Glasses: Y☐ N☐ Walker: Y☐ N☐ Cane: Y☐ N☐ Hearing Aids: Y☐ N☐

Do you own a vehicle: Y☐ N☐ Days of Attendance: Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday☐

Power of Attorney/Legal Guardian:

_____

Living Will/ Advanced Directive:_____

Income: _____SSI Social Security: _____

Emergency Contact:_____Phone Number:_____

Relationship: _____