

WERNICK ADULT DAY HEALTH CARE CENTER

Date _____ 20 _____

Name _____ Tel.No. _____

Address _____ Town _____ Zip _____

I live in _____ Own house _____ with children
_____ Apartment _____ with relatives

Date of Birth: _____ Birthplace _____

Marital

Status: _____ Single _____ Married _____ Widowed _____ Seperated _____ Divorced

Spouse's name _____ Yrs. Married _____

If widowed give date of death _____

No. of children _____ Sons _____ Daughters _____

Name	Street	City	Tel.# Home	Tel.# Work	Tel.# Cell#
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Occupation _____ Last employment _____

Emergency Contact: Name of nearest kin to be notified in case of illness

_____ Telephone# Home _____

Work _____

Cell _____

Other relatives: _____

Social Security No: _____ Amount \$ _____

Medicare No. _____ Medex _____ Plan _____

Other _____

(please bring all cards for interview)

Are you a recipient of Medicaid _____ Yes _____ No

If yes, Medicaid No. _____

Reason for application to the program _____

Have you ever attended other Adult Day Program ___ Yes ___ No

If so, reason for leaving _____

Do you have transportation to and from the Adult Day Program ___ Yes ___ No

Health

1. Diagnosis of illness _____

2. Mental Status: Alert _____ Impaired _____
extent of impairment _____ Occasionally _____ continuously

3. Ambulation: _____ without assistance _____ with assistance
Please check: _____ cane _____ walker _____ crutches _____ wheelchair

4. Are senses impaired (please check) Sight _____ hearing _____ speech _____
Other _____

5. Special diet: _____ yes _____ No. If yes, describe _____

6 Physician: Name _____

Address: _____

Tel No. _____

7. Date of last physical examination _____

It is required that an applicant have a physical examination by a physician, licensed in The Commonwealth of Massachusetts, within three months prior to admission into the Day health program.

8. Pertinent Medical History _____

9. Hospitalizations in the past five years:

Hospital	Date	Reason
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Date of onset of illness: _____

Signature of Person making application: _____

Please return to: Wernick Adult Day Health Care Center,

770 Converse Street, Longmeadow, MA 01106 ATTN: Charlene Drake

