

Applicant Information Sheet

Name: _____ Inquiry Date: _____

Address _____ City/State/Zip _____ County _____

Phone _____ Referred By _____

Reason for services: _____

Gender: M F DOB: _____ Social Security #: _____

Marital Status: S D M W Spouse Name _____

Education _____ Former Occupation _____

Ethnicity: _____ Religious Affiliation _____

Veteran? Y N Branch _____ Receiving VA Medical Benefits? Y N

Lives alone? Y N Lives with/relationship _____

Transport to ADS _____ Transport from ADS _____

Applicant Representative/Relationship: _____

Phone #: _____ email address: _____

EMERGENCY CONTACTS: Please list in order of preference for contact in an emergency.

	Name/Relationship	Daytime Phone	Address			
1.	_____	_____	_____	Caregiver? Y N	POA/DPOA/Guardian	Working? Y N
2.	_____	_____	_____	Caregiver? Y N	POA/DPOA/Guardian	Working? Y N
3.	_____	_____	_____	Caregiver? Y N	POA/DPOA/Guardian	Working? Y N
4.	_____	_____	_____	Caregiver? Y N	POA/DPOA/Guardian	Working? Y N

UNAUTHORIZED VISITORS/TRANSPORT:

	Name	Relationship	Specific Instructions
1.	_____	_____	_____
2.	_____	_____	_____

MEDICAL INFORMATION

Diagnoses: _____

Medication/Food Allergies? Y N If yes, list: _____

Diet: ___ Regular ___ Lib. Diabetic ___ NAS ___ Special instructions: _____

History of seizures? Y N Falls? Y N DNR? Y N Advanced Directive? Y N

Other medical needs/issues: _____

Primary Physician: Name/Group _____

Address _____ City/State/Zip _____

Phone _____ Fax _____ Pref. Hospital _____

Medicare # _____ Medicaid # _____

Private Insurance Carrier _____ Group/ID#s _____

CARE NEEDS

Name: _____ Name I Prefer to be called: _____

My Primary Caregiver and Where I Live Now: _____

Transfer Ability/Walking Ability/Equipment Aids in Use: _____

Toileting & Hygiene Needs: _____

Mealtime Needs/Food Preferences: _____

Physical Challenges: _____

Forgetful? Y N Confused? Y N Delusions? Y N Wander Risk? Y N Sundowners? Y N

Challenging Behaviors? Y N Examples: _____

Agitation in AM/PM? Anxiety in AM/PM? Vision _____ Hearing _____

Preferred communication style? (verbal/non-verbal, initiates conversation, prefers others to initiate conversation, yes/no questions and answers, etc.) _____

Interests/Hobbies/Skills (Things you enjoy past and present? Things that make you laugh? Things that bring you joy? Etc.)

Life Story (i.e. Did you get married? Did you have children? Where did you grow up? Career? Did you travel and where? Etc.)

About Me:

Things I Like to Talk About: _____

Personal Items that Bring Me Security or Comfort: _____

Questions I Might Ask Throughout My Day: _____

My Daily Routine at Home: _____

Favorite Type of Music: _____

Favorite Foods/Beverages: _____

Things that Bother Me or Make Me Uncomfortable: _____

What People Like/Admire About Me: _____

My Personal and Career Accomplishments: _____

Recommended Program: _____ Basic Care _____ Advanced Care _____ LIFE Lessons Pay Source: _____

Trial Date & Time: _____ **Start Date:** _____

Weekly Scheduled Days: _____ **Drop Off/Pick Up Time:** _____

Staff Signature: _____