

Applicant Information Sheet

Name: _____ Inquiry Date: _____

Phone _____ Referred By _____

Address _____ City/State/Zip _____ County _____

Reason for services: _____

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

Marital Status: S D M W Spouse Name (if applicable): _____

Education _____ Former Occupation _____ Religious Affiliation _____

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

Lives alone? Y N Lives with: _____ Relation: _____

Transport to ADH _____ Transport from ADH _____

Applicant Representative: _____ **Relationship:** _____

Phone #: _____ **E-mail address:** _____

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

Name/Relationship	Phone	Address	Caregiver?	DPOA	Guardian	Working?
1. _____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> DPOA	<input type="checkbox"/> Guardian	<input type="checkbox"/> Y <input type="checkbox"/> N
2. _____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> DPOA	<input type="checkbox"/> Guardian	<input type="checkbox"/> Y <input type="checkbox"/> N
3. _____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> DPOA	<input type="checkbox"/> Guardian	<input type="checkbox"/> Y <input type="checkbox"/> N
4. _____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> DPOA	<input type="checkbox"/> Guardian	<input type="checkbox"/> Y <input type="checkbox"/> N

UNAUTHORIZED VISITORS/TRANSPORT:

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

MEDICAL INFORMATION

Diagnoses: _____

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

Diet: Regular RCS NAS Special instructions: _____

History of seizures? Y N Falls? Y N Falls last 3 months: Y N Injury from falls: Y N

DNR? Y N Advanced Directive? Y N Other medical needs/issues: _____

Primary Physician: _____ Pref. Hospital: _____

Address: _____ City/State/Zip _____ Phone _____ Fax _____

Medicare # _____ Medicaid # _____ Private Insurance Carrier _____ Group/ID#s _____

SERVICES RECEIVED PRIOR TO ENROLLMENT:

- | | |
|--|---|
| <input type="checkbox"/> Senior Services | <input type="checkbox"/> Private Care |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Home Meal Delivery |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> ADvantage |
| <input type="checkbox"/> Other: _____ | |

CARE NEEDS

Name: _____ Prefertobecalled: _____

Transfer Ability/Walking Ability: _____ Equipment Aids in Use: Cane Walker W/C Other: _____

Toileting & Hygiene Needs: _____ No Assist Partial Assist Total Assist

Mealtime Needs/Food Preferences: _____

Physical Challenges: _____

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

Agitation: AM PM? Anxiety: AM PM? Challenging Behaviors? Y N Examples: _____

Glasses: Y N Hearing aids: Y N Dentures? Y N Smoker: Y N Past

Preferred communication style? (verbal/non-verbal, initiates conversation, prefers others to initiate, 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. married? children? grow up? career? Travel? where? etc.) _____

ABOUT ME:

Place of Birth: _____ Ethnicity: _____ Tribe (if applic): _____ # of children: _____

Things I Like to Talk About: _____

Personal Items that Bring Me Security or Comfort: _____

Questions I Might Ask Throughout My Day: _____

Favorite Type of Music: _____ Favorite Foods/Beverages: _____

Things that Bother Me or Make Me Uncomfortable: _____

My Personal and Career Accomplishments: _____

How would you like to be contacted with ADH reminders/activities? E-mail Text Phone

E-Mail Text Phone

Recommended Program: Basic Care Advanced Care LIFE Lessons Pay Source: PP DHS ADv VA

Trial Date & Time: 1st _____ 2nd _____ 3rd _____ Start Date: _____

Weekly Scheduled Days: M T W Th F S Drop Off/Pick Up Time: _____ am/pm _____ am/pm

Staff Signature: _____ Participant Signature: _____