ActiveLife Adult Day Care
We care for people
Adult Day Health Program
: - 17 Darrin Road, Dracut, MA 01826
:-(978) 322-0092 FAX :-(978)-596-1481
: - activelifeadc@gmail.com
: - www.activelifeadc.com

Admission #: - _____

Admission Date: - ____/____/_____

Application Form for Participants

Application Date: - _____ Referring By: - _____

First Name: - _____ M.I. _____ Last Name: - _____

Address _____ Apt # _____

City _____ State _____ Zip _____ Tel _____Cell_____

E-Mail: - _____ DOB___/____/_____ Sex _____ Religion _____

Place of Birth_____ Languages Spoken _____

ID#_____ Medicaid#_____ HMO#_____

SSN#_____ Medicare#_____ Other Ins._____

Race: - _____ American Indians/Alaskan Native _____ Asian _____ Black/African American

____ Asian & White, ___ Asian & Pacific Islander ____ White-Non-Hispanic____Hispanic/Latino

Marital Status: - ☐ Never Married, ☐ Married, ☐ Widowed, ☐ Separated, ☐ Divorced.

Spouse Name _____ Years Married ____, Living ____, Deceased____

Living Arrangements: - ___Alone, ____W/Spouse, ____W/Children, ____W/Relatives, ___Others

Medical Information

Primary Care Physician _____Tel#_____

Address _____City _____ Zip _____

Specialist Drs._____

Preferred Hospital: _____Allergy_____

CURRENT MEDICATION LIST

MED	DOSE	ROUTE	FREQUENCY	MED	DOSE	ROUTE	FREQUENCY

Medical Problem: _____

_____

Is Applicant able to sign documents? _____Yes ____No_____

If No Name of Responsible Person_____Relationship_____

Does applicant have Legal Guardian_____Yes ____No If Yes Name Address & Tel No._____?

_____

Has the applicant signed a Power of Attorney? _____Yes ____No If Yes Name Address & Tel No

_____

Emergency Contact: Names & Tel No.

Primary Care Giver Name: - _____ Cell: - _____

Second Care Giver Name: - _____ Cell: - _____

Preferred Days of Attendance Circle it

1st Choice Mon Tues Wed Thurs Fri / **2nd Choice** Mon Tues Wed Thurs Fri

Support System Family & Friends

Name	Relationship	Contact Frequency	Help Provided

Community Support Services used by Applicant (check all that apply)

___Meals on Wheels___Senior Center___ Senior Transportation ____ Shopping____ Home HHA ____ Respite

___ Social Services____ Hospice___ Visiting Nurse ____Others_____

Education: ____Grammar _____High School _____College _____

Employment History: _____

Special Interests:

Current Clubs/Organizations: _____

Preferred Activities _____Alone_____In-group, Special Talents_____

Hobbies or Interests_____

Nutritional Status

Special Diet_____. Appetite ____. Good ____. Fair ____. Poor, Favorite Foods_____.

Personal Information

	IND	NEEDS ASSIST	UNABLE		IND	NEEDS ASSIST	UNABLE
DRESSING:				**BOWEL FUNCTIONING:**			
Shoes &Stockings				Controlled			
Outer Clothing				Involuntary			
Under Clothing				Constipation			
Diet: Dentures U__ L__				**FUNCTIONAL LIMITATIONS:**			
Feeds Self				Travels Alone			
PERSONAL HYGINE:				In and Out of Car			
Bathing				Walks Unassisted			
Mouth Care				Climbs Stairs			
Shampoo, Hair Grooming				Transfers chair to toilet			
Shaving				Cane, Crutches, Walker			
Toileting				Manages Wheelchair			
BLADDER FUNCTIONING:				**COMMUNICATION ABILITIES:**			
Continent				Vision			
Incontinent				Hearing			
Catheter Drainage				Speech			

Do you have memory loss? _____Yes _____No

Balance: Walking: _____ Standing: _____ Sitting: _____

Signature of Participant/Responsible Person_____ Date_____