****

**Admission Application**

**Member Name**

(Last) (First) (Middle)

**Address**

(Street/Apt.) (City) (State) (Zip)

**Date of Birth** / / **Phone** ( ) \_\_\_\_ - \_\_\_\_\_ **Social Security #** \_\_\_\_ -\_\_\_\_\_ - \_\_\_\_\_\_

(MM) (DD) (YYYY)

**Marital Status** (circle) **Married Single Divorced Widowed Name of spouse** (if living):

**With whom does applicant live?** **Relationship**

**Requested start date**

**Day(s) member will be attending:** (circle) Monday Tuesday Wednesday Thursday Friday

**Approximate times:** Drop off: \_\_\_\_\_\_\_\_\_\_\_\_ Pick up: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Transported by:** (circle) Caregiver / Family / Call-a-Bus / Other

**Transportation assistance required?** Yes / No Explain:

|  |
| --- |
| **Individual responsible for payment for services: (Current Rate: $\_\_\_\_\_/Day)****Name** **Phone** **Address** (Street) (City) (State) (Zip)**Email:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How would you like the invoice to be sent:** Mail / Email / Both |

|  |
| --- |
| **Agency responsible for payment for services:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Agency responsible for payment for services:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Person completing form** (please print) **Date**

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**

**Admission p.2 Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**First Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (City) (State) (Zip)

**Home Phone:** ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ **Cell Phone:** ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ **Work Phone:** ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agree to receive updates regarding program by:** (circle) Text / Email / Both

**Second Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (City) (State) (Zip)

**Home Phone:** ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ **Cell Phone:** ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ **Work Phone:** ( ) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agree to receive updates regarding program by:** (circle) Text / Email / Both

**Admission Agreement**

Attendance at Silver Fox Adult Day Centers is a reserved day for the member, allowing us to appropriately staff the facility and anticipate our dining and activity needs. At the time of registration, a space will be reserved for a particular day(s) of the week for the member and will not be given to any other member. If a member will be absent on a reserved day, notification must be made as soon as possible. Silver Fox will attempt to make arrangements for another day in that same week, if the census allows, to eliminate the absenteeism. This arrangement must be approved by the Program Manager or Executive Director. If the cancellation is unable to be rescheduled, a cancellation fee of $30.00 will be applied. Cancellation fees may be waived, at the discretion of the Executive Director, if the member has a serious illness that causes him/her to be homebound or hospitalized. If the member has a planned vacation, please provide a minimum of two weeks’ notice to avoid cancellation fees.

If the member or family wish to alter the current reservation, please advise the Program Manager or Executive Director so an updated reservation form can be completed.

This Agreement may be terminated by the Member/Family and/or Silver Fox Adult Day Centers at any time.

**Person completing form** (please print) **Date**

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relationship**

**Admission p.3 Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**Applicant Health History:**

**List any major operations, chronic illnesses, and medical conditions, both physical or cognitive (Current or Past)**

**Primary Physician**  **Phone**

**Specialist Physician**  **Phone**

**Preferred hospital**

**What assistance is required in the following areas?**

* Walking Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Standing Explain
* Toileting Explain
* Bathing Explain
* Eating Explain
* Other Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dietary Requirements**

* Regular Diet
* Low Sodium
* Diabetic
* Swallowing Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**

Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person completing form** (please print) **Date**

**Signature**  **Relationship**

**Admission p.4 Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

 **Adaptive Equipment Continence**

 **(Please check all that apply) (Please check all that apply)**

|  |  |
| --- | --- |
| * Glasses
* Hearing Aides
* Dentures/Partials
* Gait belt
 | * Cane/Walker
* Wheelchair
* Prosthetic
* Other \_\_\_\_\_\_\_\_\_\_
 |

|  |  |
| --- | --- |
| * Continent
* Incontinent
* Depends
* Pads
 | * Catheter
* Ostomy Bag
* Other: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Medications\*** | **Dosage** | **Frequency** | **Reason/Diagnosis** |
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At any time, is supervision or help required with medications? Yes / No

Will medications be given during attendance at Silver Fox? Yes / No

\*If the member’s medications change at any point during attendance, whether the medication is taken at home or at the program, it is the responsibility of the family to inform the Program Manager immediately so the member’s file can be updated. **Initial \_\_\_\_\_\_\_\_**

**Allergies:**

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person completing form** (please print) **Date**

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**

**Staff Authorization**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_