



Harold Sherman Adult Day Center

Application for Enrollment Adult for Day Care/ Day Health Services

Applicant's full name: _____

Address: _____

Phone: _____ DOB: _____ Sex: ____ SSN: _____

Information About Applicant

Why are you interested in coming to this program? _____

Have you had previous experience in a Day program? ___ Yes ___ No

If yes, where and when? _____

Do you have any personal concerns or information that may impact on our provision of care to this participant? No Yes If Yes, Please Explain: _____

Marital Status: ___ Married ___ Single ___ Separated ___ Widowed ___ Divorced

Present Living Arrangements: ___ With spouse ___ With relatives ___ With Non-Relatives
___ Alone in House or Apartment ___ Alone in Single Room

If living with someone employed, employer: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Home Address: _____

Emergency Care Information

Please list the names of two persons who may be contacted in case of emergency:

(1) Name Relationship to Applicant

Address Telephone / Cell Phone Number(s)

(2) Name Relationship to Applicant

Address Telephone / Cell Phone Number(s)

Name of Physician: _____ Telephone: _____

Name of Dentist: _____ Telephone: _____

Services and Agreements

Transportation will be provided by: Relative or Friend _____
 Public/Private Transportation: Name _____
 Day Care Program

I agree that participation in this program will be paid by:
____ Department of Social Services ____ CAP/Medicaid ____ Veterans Administration
____ Participant ____ Caregiver/Relative Name: _____
____ Other _____

Days of Attendance: (Please Circle) M T W Th F

Arrival Time: _____ Departure Time: _____

Special dietary needs, if any: _____
(Attach a copy of the doctor's orders if on a therapeutic diet)

Supportive devices used by applicant:

- Cane Walker Wheelchair Hearing aid Dentures
- Eyeglasses (contacts) Other, please list: _____

Service Agreement

This participant does not require a POA, may make his/her own medical or other decisions, and may sign for his/herself legally.

Participant (named below) has a Power of Attorney or legal guardian (POA document shown)
Name of POA/guardian _____ Phone # of POA/guardian _____

Participant has an advance directive

I will provide the day program with and original copy.

Participant does not have an advance directive.

I would like information on how to obtain an advance directive.

Participant does not want an advance directive.

Participant has a DNR order.

I will provide the day program with an original copy.

The Healthcare Coordinator will administer medications, if needed, as prescribed. I will provide these medications in the containers as dispensed with their proper labeling as per state requirements.

All medications will be locked and distributed at time prescribed.

It is the responsibility of the participant and/or responsible party to notify the Center of any changes in medication, health conditions, etc.

I have received a copy of my Participants Rights in my enrollment packet.

- I agree to adhere to the program requirements by having an annual physical and tuberculin skin test or physician verification of being free of communicable disease. The results will be maintained as a part of my confidential program health records.
- I hereby authorize/ not authorize the Harold Sherman Adult Day Center to use my pictures, video, slides or tape recording of me for publicity, our in-house photo album and/or news releases relating to the Harold Sherman Adult Day Center.
- I hereby authorize the Harold Sherman Adult Day Center to take photographs and create a “scent-pack” to be confidentially maintained and used only for identification purposes. I authorize my name with these forms of identification.
- The Harold Sherman Adult Day Center has my permission to transport this participant on field trips and/or to and from the facility as needed. I will be notified by staff of each field trip.
- All items brought to the Center must be marked. The Harold Sherman Adult Day Center will not be held responsible for missing or lost items.
- If emergency medical care becomes necessary, I give permission for any treatment the physician deems necessary.
- The day care program's policies have been explained to me and I have been given a copy of them and agree to abide by them.
- I acknowledge that I have received Granville Health System/ Harold Sherman Adult Day Center’s Notice of Privacy Practices. I understand that the notice and disclosures of my protected health information by Granville Health System/ Harold Sherman Adult Day Center informs me of rights and respect of my protected health information. A signed authorization and specifics regarding the release of information will be signed at each information request, when indicated by law.

Applicant Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Witness Signature: _____ Date: _____