Wartburg

Adult Day Health Services
At the Wartburg

Application for Admission

This application must be submitted before any individual can be considered for admission. Submitting an application does not create any entitlement to admission to the program or mean that the applicant will be placed on a waiting list.

In compliance with New York State and Federal laws which prohibit discrimination based on race, creed, color, national origin, blindness and handicap, sex, sexual preference, age, marital status, and source of payment, The Wartburg treats all applicants on this non-discriminatory basis.

REGISTRANT INFORMATION			
First Name:	Middle:	Last Name:	
Address:		City:	
		State:	
Referral Source:		Zip:	
Home Telephone		☐ Male ☐ Female	
BACKGROUND INFORMATION			
Date of Birth:	U.S. Citizen	☐ Yes ☐ No	Religion:
		☐ Green Card	Clergy Name:
Mother's Maiden Name:			Congregation:
Father's Name:			Address:
Place of Birth:			
Social Security #:			Telephone:
HEALTH INSURANCE INFORMATION			
Medicare #		Medicaid #	
Supplemental Medicare			
Policy #			
Major Medical Carrier			
Policy #			
CONTACT INFORMATION			
First Name:	Middle:	Last Name:	
Address:		City:	
		State:	Zip:
Home Phone:	Business Phone:	Cell Phone:	
Relationship to Registrant:		Email:	
NEXT CONTACT			
First Name:	Middle:	Last Name:	
Address:		City:	
		State:	Zip:
Home Phone:	Business Phone:	Cell Phone:	
Relationship to Registrant:		Email:	
MEDICAL INFORMATION			
Name of Primary Physician:			
Address:		City:	
		State:	Zip:
Phone - Office	Emergency:	Fax:	

What do you prefer to use?		
Weight:	Height:	
List any serious illness in the past five years:		
List any current illnesses or disabilities:		
List any allergies to medication or food:		
Indicate any special equipment you use:		
Do you have ☐ Dentures ☐ Hearing Aids ☐ Pacemaker ☐ Special Appliances ☐ Other (specify)		
List any recent hospitalizations:		
Dates	Name of Hospital/Nursing Home	Reason
Psychosocial Information		
Former Occupation:		Date Last Employed:
Education (describe):		
Are you: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced		
Name of Spouse:	Occupation:	
Date of Marriage:	Spouse Deceased ☐ No ☐ Yes	When:
Living Arrangements: ☐ Son/Daughter ☐ Other: _____ ☐ Alone ☐ Niece/Nephew		
Housing: ☐ Private House ☐ Apartment ☐ Co-op ☐ Condo ☐ Group Home ☐ Other		
Do you have home care services: ☐ No ☐ Yes	☐ Aides ☐ Nurses ☐ Other:	
If yes, what days and hours do you have home care assistance:		
Do you have any of the following: ☐ Health Care Proxy ☐ Living Will ☐ Medical Power of Attorney ☐ Do Not Resuscitate Order		
What do you currently do to occupy your time at home?		
Describe your relationship with your family.		
Describe why you would like to attend Adult Day Health Services:		

To the best of my knowledge and belief, the information provided herein is accurate and true in all respects.

Signature of Applicant: _____ Date: _____

Signature of Applicant's Representative: _____ Date: _____