



GOLDEN HOME

Adult Day Care

33116 Palmer Road, Westland, MI- 48186

Phone: (734) 422-6340 Fax: (734) 422-6341

Email: adulthoodcare.goldenhome@gmail.com

APPLICATION FOR ADMISSION

A. PARTICIPANT INFORMATION:

Full Name _____ Age _____
(First) (Middle) (Last)

Preferred Name _____ Birth Date _____ Sex M F

Address _____ Phone- () _____ - _____

Present Living situation _____

Name of Spouse _____ Occupation _____

Spouse Deceased Yes No If Yes, when, _____

Living Arrangements Son/ Daughter Niece/Nephew Alone Other (Specify) _____

SSN _____ - _____ - _____

B. FINANCIAL INFORMATION:

Payment Method :-

Medicare _____ Yes _____ No

Medicaid _____ Yes _____ No

Private Pay _____ Yes _____ No

Medicaid # _____

Supplemental Insurance _____ Yes _____ NO

If Yes, specify _____
(Company Name and Policy Number)

Current Occupation: _____

Former Occupations _____

Monthly Income _____

Educational Level Completed _____ Ability to Read Yes No

Language Spoken: 1) _____ 2) _____ 3) _____ 4) _____

Veteran Yes No War _____

Branch of Service _____

Power of Attorney for Legal Affairs ? _____

Guardian _____

Durable Medical Power of Attorney? _____

C. EMERGENCY CONTACT INFORMATION

Full name _____
(First Name) (Middle) (Last)

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____

D. HEALTH INFORMATION :

Primary Health/ Diagnosis _____

Other Significant Conditions _____

Mental /Emotional/ Psychiatric Conditions _____

Primary Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Hospital Preference _____ Date last admitted _____

Other Physician Rendering Care:

	Name	Type of Care	Address	Phone #
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____

Other Services currently receiving
Therapy (Physical/ Speech/ Occupational) _____

In Home care _____

List any allergies to food or medication _____

Indicate any special equipment you use: _____

Do you have Dentures Hearing Aids Pacemaker Special appliance Other (Specify) _____

Do you have any of the following: Health care Proxy Living Will
 Medical Power of Attorney Do Not Resuscitate Order

E. ACTIVITIES OF DAILY LIVING ASSESSMENT

Please check the appropriate box

Activity	Need Complete assistance	Need some Help	Is able to do with use of device	Independent
Bathing				
Dressing				
Transferring				
Eating/ Feeding				
Bowel				
Bladder				
Walking				
Wheeling				
Stair Climbing				
Mobility				
Meal Prep				
Housekeeping				
Laundry				
Transportation				
Shopping				
Using phone				
Home Maintenance				

Has the participant experienced any of the following behaviors?

Wandering Yes No Aggression Yes No Confusion Yes No

Leisure Activates

Please place an X in the space next to the activity your family member currently does or would have interest. Please write in specifics by the activities marked in the space provided

- ___ Animal/pets ___ Discussions ___ Painting/ Drawing ___ Singing
- ___ Bingo ___ Exercise/ Walks ___ Playing an instrument ___ Sports
- ___ Cards ___ Pool/ Billiards ___ Gardening ___ Puzzles
- ___ Cooking/ Baking ___ Puzzles ___ TV shows/ Movies ___ Craft
- ___ Music ___ Reading ___ Word Game ___ Dancing
- ___ News/ Current Events ___ Quilting

F. Registration Information

Planned days of attendance/ week M T W TH F

Hours of attendance from: _____ To _____

When do you want to start? _____

Transportation to center by: Family _____ Office/ Agency _____ Other _____

Waiver : In case of illness/ emergency, I give permission to Golden Home personnel to obtain qualified medical assistance, including : ambulance service, hospital, or physician, for the above named applicant

Signature of person completing this applicant _____

Printed name of person signing _____

Relationship to Applicant _____

Date : _____

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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: _____