YWCA ADULT DAY SERVICES CENTER
APPLICATION FOR ADMISSION

Name of Potential Client: _____ Application Date: _____

Birthdate: _____ Age: _____ Sex: o Male o Female

Street Address: _____

City: _____ State: _____ ZipCode: _____

Telephone: _____ Social Security #: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

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

Name of Spouse (if applicable): _____

Name of Caretaker/Responsible Party (if applicable): _____

Street Address: (if different from above)_____

City: _____ State: _____ ZipCode: _____

Is this address a group living arrangement? _____

Telephone Number of Caretaker/ Responsible Party: _____

Functional Status of Client:

Continent: o Yes o No o If no, please explain: _____

Ambulatory: o Yes o No o If no, list devices used: _____

Mental Status: oOriented oDisoriented oDepressed oForgetful oOther:_____

Referral Source (How did you hear about our program?):

- o Agency Referral: _____ Contact Name: _____
- o Physician/Health Provider
- o Newspaper
- o Telephone Book
- o Friend/Relative
- o Advertisement (please identify): _____
- o Other: _____

Living Children (if none, list caregiver, supportive relatives, and friends):

Name	Address	Relationship	Daytime Phone #
1.			
2.			

3. _____

Living Arrangements: o Alone o with Spouse o with Children o Other: _____

Type of Dwelling: o House o Apartment o Other: _____

Length of time at present address: _____

Usual Means of Transportation: _____

Employment Status: _____ If retired, for how long? _____

Interest and Hobbies: _____

Church Affiliation (optional): _____

Ethnic Origin (optional): o American Indian o Asian o Black o Caucasian o Hispanic
o Other: _____

Do you have an Medical Power of Attorney? ◯ YES ◯ NO
(*If yes, copy will be necessary upon admission.)

Do you have Advanced Directives? ◯ YES ◯ NO

Admission is open to all regardless of race, color, national origin, sex, age, or disability.

Placement Recommendation:

Appropriate: oYes oNo

Center Visitation Scheduled on: _____

If no, specify reason: _____

Referred to: _____

Date Enrolled in Adult Day Services Program: _____

Date of Declined Service & Reason: _____

Hours of Care: _____

Days of the Week: _____

Snacks Provided: _____ Meal(s) Provided: ____

Caregiver Signature:_____ Date: _____

Staff Signature/Title: _____ Date:_____

YWCA OF BETHLEHEM ADULT DAY SERVICES
Client Emergency Information

Client: _____ Date of Admission: _____

Social Security Number: _____ Birthdate: _____

Address: _____

Phone: _____

Client's Primary Care Physician: _____

Office Address: _____

Office Phone: _____

Hospital Preference: _____

Diagnosis: _____

Allergies: _____

Insurance Information: _____

Case Manager: _____ I.D. #: _____

Attendance Schedule at ADC: _____

EMERGENCY CONTACTS: (please list three)

Name: _____ Relationship: _____

Address: _____

Phone: _____ Alternate Phone: _____

Name: _____ Relationship: _____

Address: _____

Phone: _____ Alternate Phone: _____

Name: _____ Relationship: _____

Address: _____

Phone: _____ Alternate Phone: _____