Circle Center Adult Day Services

4900 West Marshall Street
Richmond, Virginia 23230
(804) 355-5717

Pre-Admission Form

General Information

Name of Applicant ______________________ Male ( ) Female ( ) Age __________

Address ______________________ Birth Date ______________________

______________________ ZIP __________ Birth Place ______________________

Phone ______________________ Social Security No. ______________________

Marital Status: ______________________

Veteran: Yes / No Branch of Military: __________

Applicant Resides:

a. With ______________________ ( )
Relationship ______________________
b. Alone ______________________ ( )
c. In a Retirement Home or Nursing Home
or Assisted Living ______________________ ( )
Please Specify ______________________

Reason Seeking Daycare: Check as many as apply.

( ) Family Work ( ) Family in School ( ) Family Respite
( ) Maintain Maximum Independence
( ) Become More Independent
( ) Protection and Supervision
( ) Continuous Health Monitoring
( ) Alternative to Institutionalization
( ) Socialization ( ) Improved Mental Health

Other Care Being Received:

a. Paid Companion ______________________ ( )
b. Therapies (OT, PT, Speech) ______________________ ( )
c. Medicare Home Health ______________________ ( )
d. Medicaid Personal Care ______________________ ( )

Attendance Preferred (circle):

Number of Days Per Week 2 3 4 5 6
Day of Week Preferred/Required M T W R F S
Hours of Attendance: ______ to ______ Breakfast: Yes / No

Emergency Contacts

In order or priority, please list clearly persons to be contacted in the event of an emergency (do not list personal physician)

1) Name (primary caregiver) ______________________ Phone (H) __________ (W) __________ (cell) __________

Address ______________________ Relationship __________ ***email:** ______________________

City/State/Zip ______________________

**complete only if you check your email daily*

2) Name ______________________ Phone (H) __________ (W) __________ (cell) __________

Address ______________________ Relationship __________

City/State/Zip ______________________

3) Name ______________________ Phone (H) __________ (W) __________ (cell) __________

Address ______________________ Relationship __________

City/State/Zip ______________________

Place of Worship (optional) ______________________ **Former Occupation(s):** ______________________

Address ______________________

Clergy ______________________ Phone __________ **Education (# of Years):** ______________________

Medical Procedure Information

Hospital Preference ______________________ Medicaid No. ______________________

Medicare A No. ______________________ Private Insurance No. ______________________

Part B Coverage ( ) Yes ( ) No Company ______________________

Does participant have a "Do Not Resuscitate" order?
( ) **YES**, *if so, please attach a copy* ( ) **NO**

In the event of injury, illness or other emergency, I understand that Circle Center Adult Day Services will seek medical assistance from a qualified ambulance service, physician, and/or hospital.

Date: ______________ Signature: ______________________

Income Verification

Participant's Monthly Income: ______________________

Spouse's Monthly Income (if applicable): ______________________

Financial Obligation

Individual who will handle financial matters for applicant:

Name: ______________________

Address: ______________________ ______________________

Phone: (H) ______________________ (W)______________________

Is this person (circle): Legal Guardian POA Personal Representative

Please check one statement below:

( ) I agree to pay $________ for each day that I am scheduled to attend Circle Center Adult Day Services.

( ) I am not financially able to pay the above amount. I am submitting an application for a Scholarship which, if awarded, will assist me in paying the costs for services rendered by Circle Center Adult Day Services.

( ) I would like to discuss Medicaid as payment for Center services.

Date: ______________ Signature: ______________________
(Applicant/Responsible Family Member)

Date: ______________ Signature: ______________________
(Executive Director, or designated representative, Circle Center Adult Day Services)