

# Circle Center Adult Day Services

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



## Pre-Admission Form

### General Information

Name of Applicant \_\_\_\_\_

Address \_\_\_\_\_

ZIP \_\_\_\_\_

Phone \_\_\_\_\_

Male ( ) Female ( ) Age \_\_\_\_\_ Birth Date \_\_\_\_\_

### Applicant Resides:

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

### Other Care Being Received:

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

### 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):** \_\_\_\_\_

<b>Office Use Only</b>	
Accepted: _____	Medical Statement: _____
Admitted: _____	Discharged: _____

Birth Place \_\_\_\_\_

Social Security No. \_\_\_\_\_

Marital Status: \_\_\_\_\_

Veteran: Yes / No Branch of Military: \_\_\_\_\_

- 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

### Attendance Preferred (circle):

Number of Days Per Week    3    4    5    6

Day of Week Preferred/Required    M T W R F S

Hours of Attendance: \_\_\_\_\_ to \_\_\_\_\_ Breakfast: Yes / No

## Medical Procedure Information

Hospital Preference \_\_\_\_\_ Medicaid No. \_\_\_\_\_  
Medicare No. \_\_\_\_\_ Private Insurance No. \_\_\_\_\_  
Funeral home: \_\_\_\_\_ 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): \_\_\_\_\_

### Handbook

I have received a copy of the Participant and Caregiver Handbook for my review.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### 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)**