Circle Center Adult Day Services

4900 West Marshall Street
Richmond, Virginia 23230
(804) 355-5717 Main
1-844-466-2538 Fax

Pre-Admission Form

Office Use Only
Accepted: _____ Medical Statement: _____
Admitted: _____ Discharged: _____

General Information

Name of Applicant _____

Address _____

_____ ZIP _____

Phone _____

Male ( ) Female ( ) Age _____ Birth Date _____

Birth Place _____

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 _____

Other Care Being Received:

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

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

Day of Week Preferred/Required M T W R F

Hours of Attendance: _____ to _____

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 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)