

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 _____
Directions to Home _____

Male () Female () Age _____
Birth date _____
Birth Place _____
Social Security No. _____
Marital Status _____

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

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 _____

<p>Place of Worship (optional) _____ Former Occupation(s): _____ Address _____ Clergy _____ Phone _____ Education (# of Years): _____</p>
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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 original () **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: _____

Photo Release

I give permission to use, publish and republish photos of me (or my relative) for non-commercial purposes, to further the work of this center.

() **YES** () **NO**

I authorize the use of my name, if needed.

() **YES** () **NO**

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)