DAY BREAK - Adult Day Health Care
APPLICATION FOR ADMISSION
(Please print)

Applicant's Name	Sex M F	Marital Status S M D Sep W	DOB
Address		Phone	
Planned Transporter	Phone	Requested Days of Attendance M T W Th F	

MEDICAL INFORMATION

Attending Physician	Address		Phone Fax
Physician's Hospital		*DNR yes/no	*Health Care Proxy- yes/no Agent-
Other Doctor's Involved 1.	Address		Phone Fax
2.	Address		Phone Fax

FINANCIAL/PAYMENT INFORMATION

*Social Security #	*Medicare #	*Medicaid #
*Other Insurance (i.e. BC, BS)	*Managed Care Plan	
Financially Responsible Party		POA yes / no

PLEASE BRING COPIES OF ALL STARRED ITEMS

FAMILY/EMERGENCY CONTACTS

Relative/ Friend	Relationship	Home Phone
Address		Work Phone
Other Relative/ Friend	Relationship	Home Phone

DAY BREAK

Birthplace_____ Nationality_____

Primary Language_____

Marital Status: Single_____ Married_____ Widowed_____

Divorced_____ Separated_____

Name of Spouse_____ Number of Children_____

Applicant's Education_____

Applicant's Former Occupation_____

Company Name_____ Retirement Date_____

Leisure Interests & Hobbies-Current & Former

_____ _____

_____ _____

It is the policy of St. John's Home and all it's programs to admit prospective clients without regard to race, color, creed, religion, national origin, gender, marital status, sexual preference, disability, blindness, sponsor or age.

Medical Diagnoses:_____
_____
_____
_____

PROFESSIONAL/AGENCIES WORKING WITH CLIENT

Check All That Apply

Name of Home Health Care Agency _____

Case Manager ,name and phone no. _____

_____Pharmacy _____

NUTRITION

1. What is your height? _____ Weight_____

2. Do you follow a special diet/consistency at home? Yes____ No____ What kind?_____

3. Please specify any specific food dislikes, intolerances and/or food allergires?_____
_____

FUNCTIONAL ASSESSMENT

PLEASE X OR CIRCLE APPROPRIATE CHOICE

TASKS	Able to do alone	Needs help	Unable to perform	Please describe the assistance needed
WALKING/AMBULATION				
Walks				
Uses walker/cane (circle one)				
Wheels own wheelchair				
Gets on/off a chair				
TOILETING				
Gets on/off toilet				
Adjusts own clothing before/after toileting				
Has bladder control yes/no (circle one)				
Has bowel control yes/no (circle one)				
Changes own incontinence protection				
EATING				
Able to choose food items from a menu				
Able to cut food				
Eats independently				
Needs reminders to eat				

GENERAL SOCIAL/WELL-BEING ASSESSMENT

ATTITUDE & ABILITIES	YES	NO	SOME-TIMES	PLEASE COMMENT
Is comfortable interacting & enjoys being with others				
Adjusts well to change				
Makes own decisions				
Cooperates with care				
Has short term memory problems				
Has long term memory problems				
Has a history of mental health problems				
Expresses or shows sadness				
Expresses or shows anger				
Is anxious, restless				
Is easily distracted				
Can occupy self when left alone				
Can be left alone				

Signature of Person Completing Form _____Date_____

Relationship_____