

Adult Day Center of Somerset County, Inc.

120 Findeme Avenue
Bridgewater, NJ 08807
phone: (908) 725-0068
fax: (908) 725-2995

Application

Applicant's name: _____

**Person Completing
Application:** _____

Relation: _____

Referred by: _____

Signature: _____

Date: _____

ADULT DAY CENTER APPLICATION

APPLICANT INFO

Name: _____ Gender: ___ M ___ F
Address: _____ Birthdate: _____
_____ SS#: _____
Phone: _____ Marital Status: ___ S ___ M ___ W ___ D
Living Arrangements: Medicare #: _____
___ with family Medicaid #: _____
___ alone Living Will: ___ Y ___ N
___ boarding home Durable POA: ___ Y ___ N
___ other: _____ Name of POA: _____

CAREGIVER INFO

Name: _____ Home phone: _____
Address: _____ Cell phone: _____
_____ Bus. phone: _____
Place of business: _____
Ability to visit program: _____
Will you be able to assist in transportation? ___ Y ___ N

EMERGENCY CONTACTS

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

Caregiver Email:

MEDICAL INFO

Past Medical History, including any surgeries: _____

Current diagnoses: _____

Medications and dosages:

Diet: ___ Regular ___ Diabetic ___ Chopped/cut foods ___ Pureed ___ Other

ADL's:	Independent	Needs Assistance	Total Dependence	Comments
Dressing				
Toileting				
Walking				
Eating				

Orientation:	Always	Sometimes	Never	Comments
Self				
Other Persons				
Place				
Time				
Day/Date				

Place of birth: _____ Education: _____

Spouse's name: _____ Number of children: _____

Past employment: _____

Reason for Application: (check all that apply)

- Applicant unable to live alone
- Caregiver must work
- Caregiver needs respite
- Applicant needs socialization and stimulation

To be completed by Adult Day Center

Date Received: _____

Home Visit Scheduled: _____

Status of Application:

Accepted

Start Date: _____

Pending

Reason: _____

FINANCIAL INFO

Copies of check stubs, bank statements, or other evidence of income must be supplied.
Please include information for applicant and spouse (if applicable).

Applicant Name: _____ SS#: _____

Medicare #: _____ Medicaid #: _____

Other Insurance and #: _____

<u>SOURCE</u>	<u>ANNUAL AMOUNT</u>		<u>HOW VERIFIED</u>
	<u>Client</u>	<u>Spouse</u>	
Wages	_____	_____	_____
Social Security	_____	_____	_____
Pensions	_____	_____	_____
Interests, Dividends, Trusts, etc.	_____	_____	_____
Rental Income	_____	_____	_____
Other Income	_____	_____	_____
TOTAL INCOME	_____	_____	_____

Client/Caregiver Signature _____

Staff Signature _____

The information above is available only to service agency staff and public officials who require it in connection with their duties.

For office use only

SSBG eligible _____ Y _____ N

Fee assessed \$ _____ per day

Date of redetermination: _____