Adult Day Center
of Somerset County, Inc.

872 East Main Street
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: ____ with family ____ alone ____ other: _____

Medicare #: _____ **Medicaid #:** _____

Advance Directive/Living Will: ☐ Yes ☐ No

Physician's signed DNR (Do not resuscitate): ☐ Yes ☐ No

Durable POA: ☐ Yes ☐ No **Name of POA:** _____

Please provide copies for any or all of the above that apply.

CAREGIVER INFO

Name: _____ **Home Phone:** _____

Address: _____ **Cell Phone:** _____

_____

Place of business: _____ **Bus. Phone:** _____

Ability to visit program: _____

Will you be able to assist in transportation? ☐ Yes ☐ No

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	Neverr	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 #:_____

SOURCE	ANNUAL AMOUNT		HOW VERIFIED
	Client	Spouse	
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:_____