Friends Place Adult Day Services, Inc.
APPLICATION FOR ENROLLMENT

Enrollment for (check location) ___ Richardson ___Desoto

Participant Name ____
First MI Last

Current Address ____

City ______________________ State __________ Zip __________

Date of Birth ________________Age _____Marital Status ____________

Name of Spouse/ Partner /Significant Other____________ ______________

Person completing this application ______________________________
First MI Last

Relationship to participant ______________Phone# ________________

Name of Client's Representative ______________________________

Billing Address ____

City __________________________ State_______ Zip__________

Home Ph # ______________Work # ____________Cell#__________

Email Address____

#2 Emergency Contact ____________________Phone____________

Other Phone #s ____

How did you learn about Friends Place? __________________________

Check all that apply:
☐ Medicare ☐ VA Benefits
☐ Long Term Care Insurance

Revised 8/2014

Participant has the following Advance Directives:

☐ Medical Power of Attorney

☐ Directive to Physicians

☐ Texas Out-of-Hospital Do Not Resuscitate Form

☐ Durable Power of Attorney

☐ Guardianship

Primary Physician ____

Address ____

City _____________________________ State _________ Zip ___________

Phone # ____

Other physicians/specialists and phone numbers

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Most recent hospitalization date _____________________________________

Reason for hospitalization ____

Previous participation in an adult day service program ______________________

Previous stay in an assisted living or nursing home _________________________

Previous stay in a psychiatric hospital _________________________________

Participant has a diagnosis of Alzheimer's or related dementia ☐ Yes ☐ No

Participant has a diagnosis of dementia related to other illness or injury ☐ Yes ☐ No

Participant has a diagnosis of mental retardation ☐ Yes ☐ No

Participant has a diagnosis of any mental illness ☐ Yes ☐ No

Revised 8/2014

Participant has or has had any of the following medical problems? Check or Circle

☐ Vision problems / Glasses	☐ Hearing problems / Hearing aides
☐ Thyroid disorder	☐ Cancer
☐ Anemia	☐ Stroke
☐ Heart problems/ angina	☐ High blood pressure
☐ Pneumonia or other lung condition	☐ Tuberculosis
☐ Hay fever, asthma, allergies	☐ Headaches, dizziness, faintness
☐ Digestive disorder	☐ Unplanned weight loss or gain
☐ Dental/oral problems	☐ Diabetes
☐ Bone or muscle problem	☐ Arthritis or other joint disorder
☐ Kidney or bladder disorder	☐ Incontinence
☐ Skin disorders	☐ Sleep problems
☐ Drug allergies	☐ Food allergies
☐ Serious childhood illness or injury	☐ Serious adult illness or injury
☐ Ability to walk/ transfer out of a chair	☐ Falls

Please explain any of the items checked above ______________________________

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Participant has exhibited the following disease-related behaviors:

Wandering/pacing	☐ Never	☐ In the past	☐ Currently
Verbal aggression	☐ Never	☐ In the past	☐ Currently
Physical aggression	☐ Never	☐ In the past	☐ Currently
Socially inappropriate behavior	☐ Never	☐ In the past	☐ Currently
Resistive to assistance from caregiver	☐ Never	☐ In the past	☐ Currently
Hallucinations	☐ Never	☐ In the past	☐ Currently
Delusions	☐ Never	☐ In the past	☐ Currently
Inappropriate sexual behavior	☐ Never	☐ In the past	☐ Currently

Other ____

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ACKNOWLEDGEMENT

I certify that all information on this application is true and correct to the best of my knowledge. I understand that any intentional falsification can affect the decision for enrollment or continued enrollment in Friends Place.

I understand that completion of this application does not obligate me to accept enrollment to Friends Place if offered.

_____________________________________ _______________________
Signature of person completing application Date

Revised 8/2014