Application for Admission

P. O. Box 1497, 196 West Main St, Dudley, MA 01571
Ph: (508) 949-3598 Fax: (508) 949-3400

Client Name: ____ Date: _________________

Address: ____

Phone: ____

Soc. Security # __________________ Date of Birth _______________ Marital Status _______

Educational Level ______________________ Religious Preference _______________________

How many days a week would applicant attend Day Center? __________________________

___Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___ Saturday

Anticipated Date of Admission ____

Does applicant live alone? ___ Yes ___ No

If no, what is the situation? ____

Responsible Party ___________________________ Relationship _______________________

Address ____

Phone ________________________ Alternate Phone _________________________________

Applicant's Personal Physician: ____

Address ____

Phone _____________________________________ Fax ________________________________

Applicant's Hospital Preference ____

Diagnosis ____

Allergies _____________________________ Code Status ______________________________

Medication ____

____

Payment Source: __ Self Pay __ TRV __ MassHealth __ CCCI __ Senior __ ASN

If MassHealth, has applicant been screened for ADHC services by ASAP nurse? ___________

If Private Pay, who will receive the bill?

Name____________________________________

Address ____

Phone ____

Other Insurance or HMO: Please list name and numbers:

____

OTHER FAMILY MEMBERS:

Name ______________________________ Phone ____________________________

Address____

Relationship ____

Name ______________________________ Phone ____________________________

Address____

Relationship ____

WHO SHOULD BE CONTACTED IN CASE OF EMERGENCY?

Name __________________________________ Relationship ____________________

Address ____

Phone _______________________ Alternate Phone ___________________________

Other Agencies Involved?

Agency: _______________________ Phone: ______________________________

Type of services: ____

Case Manager: ____

Personal Finances:

Is the applicant able to manage their personal & financial affairs? ___ Yes ___ No

If no, who assumes responsibility?

Name ____________________________ Phone ___________________________

Address ____

Relationship ____

APPLICANT OR RESPONSIBLE PARTY

Signature ____________________________________ Date ___________________ Please

Print Name ____