



PARTICIPANT APPLICATION FORM

NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL SECURITY NUMBER: ____-____-____ EMAIL: _____

GROUP HOME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE: _____ MEMBER ID# _____

PRIMARY CARE PHYSICIAN: _____

PHONE: _____ FAX: _____

OTHER PHYSICIAN: _____

PHONE: _____ FAX: _____

ALLERGIES: _____

DIAGNOSIS: _____

HAVE YOU EVER BEEN CHARGED WITH A FELONY? YES or NO. IF YES, PLEASE EXPLAIN:

LIST ANY ILLNESSES FOR WHICH YOU ARE CURRENTLY RECEIVING TREATMENT:

IF ACCEPTED AS A PARTICIPANT, WOULD YOU REQUIRE TRANSPORTATION TO AND FROM GENERATIONS? YES or NO

BRIEFLY STATE WHAT YOU HOPE TO GET FROM GENERATIONS ADULT DAY HEALTH CENTER:

PLEASE LIST BELOW UP TO THREE EMERGENCY CONTACTS:

NAME: _____ PHONE: _____

RELATIONSHIP TO APPLICANT: _____

NAME: _____ PHONE: _____

RELATIONSHIP TO APPLICANT: _____

NAME: _____ PHONE: _____

RELATIONSHIP TO APPLICANT: _____

THE FOLLOWING DOCUMENTATION IS REQUIRED AS PART OF OUR ADMISSION PROCESS:

- CURRENT PHYSICAL EXAM (WITHIN 12 MONTHS)
- CURRENT MEDICATION LIST
- LAST FOUR CLINICAL NOTES FROM BEHAVIORAL HEALTH PROVIDER, PSYCHIATRIC EVALUATION (IF APPLICABLE)
- RECENT HOSPITAL DISCHARGE SUMMARY (IF APPLICABLE)
- COORDINATION OF CARE WITH OUTSIDE CASE MANAGEMENT PROVIDER OR SCHOOL TRANSITION TEAM (IF APPLICABLE)
- DOCUMENTATION IF LEGAL GUARDIAN AND/OR POWER OF ATTORNEY FOR HEALTH OR FINANCIAL

NAME: _____ DATE: _____

RELATIONSHIP TO APPLICANT: _____