GENERATIONS
Adult Day Health Center

**PARTICIPANT APPLICATION FORM**

NAME: _____DATE OF BIRTH: _____/_____/_____

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

GROUP HOME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE: _____ MEDICAID 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:

_____

267 Jenckes Hill Road, Smithfield, RI 02917 Phone: 401-725-6400 Fax: 401-333-3811
www.generationsri.com

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: _____