Life is a Dream

Adult Day Care Center

5171 Mariner Blvd Spring Hill FL 34609

Phone: _____ Fax: _____

E-Mail: lifeisadreamadc@gmail.com

Instructions:

- Fill out all requested information by printing or typing (except signatures).
- Attach pages if needed for additional information.
- Once complete, mail, fax, or scan and email application to the center.
- After receiving the application, the center will call and set up an appointment for a visit and for the applicant to be evaluated.

Admission Application

Applicant Name_____
(Last) (First) (Middle)

Address_____
(Street/Apt.) (City) (State) (Zip)

Phone_____ Social Security #_____-____-_____ Religion _____

Sex (circle) M F Age _____ Date of Birth____/____/_____ Place of Birth (city/state) _____
(MM) (DD) (YYYY)

Marital Status (circle) Married Single Divorced Widowed Name of spouse (if living): _____

With whom does applicant live?_____ Relationship_____

Alternate emergency contact_____ Phone _____

Address_____
(Street/Apt.) (City) (State) (Zip)

Applicant Health History

List any major operations, chronic illnesses, and medical conditions _____

_____

_____

_____

Personal Physician_____ Phone _____

Address_____
(Street/Apt.) (City) (State) (Zip)

Preferred hospital _____

Pharmacy_____ Phone _____

Medicare/Insurance Information

Part A Claim # _____
Part B Claim # _____
Other insurance coverage _____

Admission p. 2 Name _____

What assistance is required in the following areas?

Walking, Standing Explain _____
Toileting Explain _____
Bathing Explain _____
Eating Explain _____

Dietary Requirements

☐ Regular diet
☐ Low sodium
☐ Diabetic
☐ Other Explain _____

Current Medications	Dosage	Times Given

Is supervision or help required with medications? Yes No (circle) Explain (if yes) _____

Requested starting date _____ Days: (circle) Monday Tuesday Wednesday Thursday Friday

Transported by City Family (circle) Life is a Dream Other _____

Transportation assistance required _____

What additional special needs does the applicant have? (i.e., need for socialization, supervision, etc.) _____

_____

Name, address, and phone number of individual or agency responsible for payment of adult day care services

Name_____ Phone _____

Address_____
(Street) (City) (State) (Zip)

Applicant signature _____ Date _____

Signature of person completing this form _____ Relationship _____