



ROYAL PALM ADULT DAY CARE CENTER

PARTICIPANT DEMOGRAPHIC INFORMATION & ADMISSION FORM

Participant Information

Participant Full Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security Number (last 4 digits only): _____

Primary Language: _____

Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Start of Care (SOC) Information

Start of Care (SOC) Date: _____

Program / LTC Plan (if applicable): _____

Authorized Days of Attendance: _____

Transportation (check one):

Third-Party Transportation

Family / Caregiver

Facility

Insurance Information

Medicare: _____ Medicare HMO: _____

Medicaid: _____ Medicaid MMA: _____

Emergency Contact / Responsible Party

Name: _____

Relationship to Participant: _____

Home Phone: _____ Mobile Phone: _____

Is this person a Legal Representative? Yes No

If yes, type (check one): Power of Attorney Guardian Health Care Surrogate

(Documentation must be on file if applicable)

Primary Care Physician

Physician Name: _____

Phone Number: _____

Medical Overview

Primary Diagnosis: _____

Precautions (if any): _____

Functional Limitations (if any): _____

Participant Acknowledgment

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that this information is used for admission and care planning purposes and that I am responsible for notifying the Facility of any changes.

Participant / Legal Representative Signature: _____

Printed Name: _____

Date: _____