

ADULT DAY PROGRAM APPLICATION FOR ENROLLMENT

Date: _____

Applicant:

Name: _____ Phone: _____ Sex: _____

Address: _____ Date of Birth: _____ Age: _____

City: _____ State: _____ Zip _____ Place of Birth: _____

Marital Status: M W S SEP D Religious Affiliation: _____

Place of Worship: _____

Does Applicant have an Advanced Directive or Living Will? _____ YES _____ NO

Name of Person authorized as Durable Power Attorney: _____
(PLEASE ATTACH A COPY OF THE POWER OF ATTORNEY)

RESPONSIBLE PARTIES:

1. Name _____ Relationship _____

Address _____ Phone # _____

City _____ State _____ Zip _____ Cell. Phone # _____

Email Address _____

2. Name _____ Relationship _____

Address _____ Phone # _____

City _____ State _____ Zip _____ Cell Phone # _____

Email _____

Monthly Income:

1. Source _____ Amount _____

2. Source _____ Amount _____

INSURANCE:

Social Security # _____ **Traditional Medicare #** _____

Blue Cross/Blue Shield ID # _____ **Group #** _____ **Plan:** _____

HMO Plan and # _____ **VA #** _____

Medical Assistance # _____ **Other Insurance** _____

Name of Primary Physician _____

Address _____ **Phone #** _____

City _____ **State** _____ **Zip** _____

Please List preference for Funeral Director (In the event of an emergency situation)

Funeral Director: _____ **Phone #:** _____

Address: _____
(Street) (City) (State & Zip)

People In Your Household:

1. _____ **Relationship** _____

2. _____ **Relationship** _____

3. _____ **Relationship** _____

How were you referred to the program? _____

How many days per week are you interested in attending? _____

Will you need to use CCT Connect (Septa Para transit) to come to the program? _____

Para transit ID # _____

Signature _____ **Date** _____
(Applicant for enrollment)

Signature _____ **Date** _____
(Responsible Party and/or POA)

