THE GRAND ADULT DAY HEALTHCARE RIVER VALLEY

Admission Application

Name of Applicant: _____

Person Completing Form: _____ Date: _____

PERSONAL INFORMATION

Name of Applicant: _____ DOB: _____

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

Social Security #: _____ Medicaid: _____

Medicare #: _____ Other Insurance: _____

Source of Referral: _____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Never Married

EMERGENCY CONTACT

Name: _____ Relationship: _____

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

Phone: _____

PHYSICIAN INFORMATION

Physician Name: _____ Specialty: _____

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

Phone: _____

LIVING ARRANGEMENTS

Current Residence: ☐ private home ☐ ACF/Adult Care Facility ☐ other: specify: _____

Lives with: ☐ alone ☐ spouse/partner ☐ child
☐ parent/guardian ☐ sibling/s ☐ other relatives ☐ non-relatives

THE GRAND AT RIVER VALLEY ADHC 140 MAIN STREET POUGHKEEPSIE, NY 12601 845-454-7600

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MEDICAL INFORMATION

Medical Diagnoses, Conditions or Symptoms: _____

_____

_____

Allergies: _____

Medications: _____

_____

_____

Recent Hospitalizations: _____

ACTIVITES OF DAILY LIVING (ADLs)

Bathing:	_____ self	_____ supervision	_____ assist
Personal Hygiene:	_____ self	_____ supervision	_____ assist
Dressing:	_____ self	_____ supervision	_____ assist
Mobility:	_____ self	_____ supervision	_____ assist
Transfer:	_____ self	_____ supervision	_____ assist
Toileting:	_____ self	_____ supervision	_____ assist
Eating:	_____ self	_____ supervision	_____ assist

Assistive Devices/Medical Equipment: _____

INSTRUMENTAL ADLs

Finances:	_____ self	_____ supervision	_____ assist
Shopping:	_____ self	_____ supervision	_____ assist
Telephone Use:	_____ self	_____ supervision	_____ assist
Meal Preparation:	_____ self	_____ supervision	_____ assist
Housework:	_____ self	_____ supervision	_____ assist