
# APPLICATION FOR ENROLLMENT

**The Harbor is certified by the Division of Aging and Adult Services as a "Specialized" Adult Day Program for those with memory loss and cognitive impairment.**

## INFORMATION ABOUT APPLICANT

Applicant's Full Name: _____

Address: _____

Phone: _____ DOB: _____ Sex: _____

Marital Status: Married Single Separated Widowed Divorced

Living with Whom: _____ Relationship: _____

Home Address (If Different from Above): _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Why are you interested in coming to this program? _____

How did you find out about this program? _____

Have you had previous experience in a day program? Yes No
If yes, when and where? _____

## EMERGENCY CARE INFORMATION

Please list the names of two persons who may be contacted in case of emergency:

1._____ _____
Name Relationship to Applicant

_____ _____
Address Telephone Number

2. _____ _____
Name Relationship to Applicant

_____ _____
Address Telephone Number

Primary Care Physician: _____ Telephone: _____

Dentist: _____ Telephone: _____

## SERVICES

Transportation will be provided by: _____
Name

Desired Number of Days: _____

Desired Weekly Schedule of Attendance (Place a check on the days you are interested in):

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|
| | | | | | |

## MEDICAL

**Diagnosis of cognitive impairment is REQUIRED.**

**Specific Diagnosis:** _____

**Other Diagnosis**:_____

**Special dietary needs or food allergies,** if any: _____
Attach a copy of the doctor's orders if on a therapeutic diet.

**Supportive devices** used by applicant:

___Cane __Walker ___Wheelchair ___Hearing Aid ___Dentures

___Eyeglasses (contacts) ___Other, please list: _____

## ADVANCE DIRECTIVE NOTIFICATION

___My family member does not require a POA, may make his/her own medical or other decisions, and may sign for his/herself legally.

___My family member has a Power of Attorney or legal guardian

Name of POA/guardian _____
Phone number of POA/guardian _____

___My family member has an advance directive & I will provide the day program with an original copy.

___My family member has a DNR order & I will provide an original copy.

___My family does not have an advance directive.

**Responsible Party Signature**: _____ **Date**: _____