Home Away From Home Adult Day Health Center

150 Industrial Avenue East, Lowell MA 01852 (978) 453-4663 fax (978) 970 3895

Application for Admission:

Name____

Home
Address:____

Home Phone:___________________________ Cell Phone:
____

Social Security Number: ______________________________ Date of
Birth:_________________

Marital Status: ____________ Language Spoken: _______________Religion:
____

Emergency Contact Information:

Name:____ Relationship:
____

Address:____

Home Phone: _______________ Cell Phone:_________________ Work Phone:
____

Secondary Contact Name:____________________________
Relationship____________________

Home Phone:_____________________ Cell Phone:________________ Work
Phone__________

Third Contact: Name_____________________________________ Phone:
____

Insurance Information (Please provide copies of cards)

MassHealth
Number:____

Medicare Number
:____

Other Insurance:
____

Private Pay Billing
Information:____

____
____

Legal Information: (please provide copies)

Guardian:
____

Health Care Proxy:
____________________________DPOA_________________________

DNR status: ______________________

Community Supports:

Name and address of Primary Care Physician:
____

Preferred Hospital:
____

Other treating physicians:
____

____
____

Counseling/Psychiatry
____

Case Management:
____

Visiting
Nurse:____

Home Health Aid/Personal Care
Assistance:____

Physical/Occupational Therapy:
____

Other Services:
____

Hospitalizations in the last year: (Name of facility, Date of stay and reason for stay)

Authorization:

I affirm that everything in this application is true and correct. I hereby authorize Home Away From Home to verify this information. If any of this information changes, I will notify Home Away From Home immediately.

Signature of Applicant:
____

Signature of Responsible
Party:____

Date: __________________________________