



Rae's Playze Adult Day Center
SEEING THROUGH THE EYES OF OTHERS

Participant Registration Form

Name: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Social Security Number: _____ marital status: _____

Religion: _____ **Gender: Male Female Other** Date Enrolled: _____

Primary Caregiver's Name: _____ Relationship: _____

Street: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____ Other: _____

E-mail Address: _____

Person Responsible for Payment: _____

Address (if different from above): _____

Please list at least two people we could contact in the event of an emergency if the caregiver cannot be reached. These phone numbers must be current; please let us know if any changes occur.

Name: _____ Relationship: _____ Phone: _____

Additional number(s) for this contact: _____

Name: _____ Relationship: _____ Phone: _____

Additional number(s) for this contact: _____

Name: _____ Relationship: _____ Phone: _____

Additional number(s) for this contact: _____

Participant's Primary Physician: _____ Phone: _____

Other Physician(s): _____

Preferred Hospital (please check): Novant Health or Atrium Health

Please read the following statement, then sign and date below.

In the event of an emergency, I give permission for _____ to be transported to the nearest emergency room or to my preferred hospital (depending upon the nature of the emergency). I understand that I am responsible for all charges resulting from the emergency care, including ambulance or rescue squad charges. I also give permission for RPADC staff to provide emergency medical personnel with any information which will assist them in treatment of the emergency.

Caregiver's Signature: _____ Date: _____

Caregiver's Name (printed): _____

***Please provide Rae's Playze Adult Day Center with copies of the participant's Social Security card, insurance card(s), and Medicare card which we will keep on file in the event of an emergency.**



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INFORMATION ABOUT APPLICANT

Why are you interested in coming to this program?

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

PRESENT LIVING ARRANGEMENTS:

with spouse with relatives with non-relatives Alone in House and Apartment Alone in Single Room

Living with Whom: _____ Relationship: _____
Nearest Responsible Relative: _____ Relationship: _____

If living with someone employed, employer name: _____
Phone number of employer: _____ Home Phone: _____

SERVICES

Transportation will be provided by: Relative or friend Public Transportation Day Care Program

MONTHLY SCHEDULE OF ATTENDANCE:

Week 1	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
Week 2	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
Week 3	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
Week 4	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					
Week 5	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time:					
Departure Time:					

Special dietary needs, if any: _____

Attach is a copy of the doctor's order if on a therapeutic diet

Supportive devices used by applicant:

Cane Walker Wheelchair Hearing Aid Dentures Eyeglasses (contacts)



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ADVANCE DIRECTIVE NOTIFICATION

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

My family member has a Power of Attorney or legal guardian

Name of Power of Attorney or legal guardian _____

Phone number of Power of Attorney or legal guardian _____

My family member has an Advance Directive and I will provide the day program with the original copy. □

My family does not have an Advance Directive.

___ I would like information on how to obtain an Advance Directive

___ My family member does not want an advance directive

My family member has a DNR order.

The Adult Day Health Care Center's program policies have been explained to me and I have been given a copy of them and agree to abide by them.

If emergency medical care become necessary, I give permission for any treatment the physician deems necessary.

Applicant Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____