Main Line Adult Day Center
Home away from Home

MEMBER APPLICATION **Date:** _____

Name: _____What would you like to be called? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # _____ Birth date: _____ County:_____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Name of Spouse: _____ Spouse's Occupation: _____

Race: ❑ African American ❑ Caucasian ❑ Hispanic ❑Asian ❑Native American ❑Other:_____

Primary language spoken: _____
Other language spoken/understood_____

Living Arrangements: ❑ Alone ❑ Spouse ❑ Child ❑Other: _____

Type of Dwelling: ❑ House ❑ Apartment ❑ Other: _____
Length of time at present address: _____

US Veteran: ❑ Yes ❑ No Which Branch of Service? _____ Rank: _____
Are you currently receiving VA benefits? ❑ Yes ❑ No

Employment:
Primary Occupation: _____ How Long Retired? _____

Other occupations/volunteer positions held: _____

Education:
Highest Grade Completed: _____ Studies of Interest: _____
_____

Support Information/Other Community Contacts:
Please list any health and/or social services agency with whom you are currently working with:
(Home care, Hospice, Transportation, Area Agency on Aging)

Agency Name	Phone	Contact Person	Reason for Contact

Primary Caregiver Information ❑ **Also Emergency contact**

Primary Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # _____ Work phone # _____

Cell # _____ E-mail _____

Additional Emergency Contact:

Primary Contact: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone # _____ Work phone # _____ Cell # _____

Family/Social Supports:
Please list names of participant's **parents** and their occupations:
Father: _____ Occupation: _____
Mother:_____ Occupation: _____

Please list participant's **siblings**: _____
_____
Please list participant's **children.** (If none list supportive relatives and friends):
_____
_____
Please list participant's **grandchildren:** _____
_____

Pets: _____ Names: _____

Church affiliation (optional): _____
Spiritual importance: _____

Interests and Activities:

	Current	Past		Current	Past
Socializing	_____	_____	Religious Topics	_____	_____
Physical Exercise	_____	_____	Poetry	_____	_____
Discussion Groups	_____	_____	Book Review	_____	_____
Television	_____	_____	Reading	_____	_____
Current Events	_____	_____	Crafts	_____	_____
Card Games	_____	_____	Cooking	_____	_____
Table Games	_____	_____	Music	_____	_____
Gardening	_____	_____	Field Trips	_____	_____
Bingo	_____	_____	Movies	_____	_____
Pets	_____	_____			

Other:_____

Organizations, affiliations and awards: _____

Caregiver's expectations of Adult Day Service: _____
_____

Advanced Directive:
Do you have an advanced directive? ❑ No ❑ Yes (if yes, please attach copy)
Name of person authorized to make health care decisions under advanced directive:

Name: _____ Relationship: _____ Daytime phone _____

Medical Information:

Primary Care Physician's Name: _____ Phone No. (_____)_____
Address: _____
Street City State Zip

Additional physicians/healthcare practitioners

Name: _____ Phone No. (_____)_____
Specialty: _____
Address: _____
Street City State Zip

Medical Insurance Coverage:

Primary: _____

Secondary: _____

Additional Services

Are you interested in any of the following services which are available at the Centers for a separate fee?

- ❑ Shower - Day of week desired: _____
- ❑ Physical Therapy, Occupational Therapy, Speech Therapy* _____
- ❑ Hair care* – Type of service:_____ Frequency: _____
- ❑ Podiatry*

* These services are provided at the Centers by individuals and/or entities other than MCSS.

Signatures:

Signature of applicant (if able): _____ Date: _____/_____/_____

Signature of caregiver: _____ Date: _____/_____/_____

_____
Signature of staff person reviewing application at intake* Date: _____/_____/_____

* note: staff should date and initial all additions/corrections to this form.

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updated: 3/5/2018