Total Life Center
Application for Admission

Full Name of Applicant: _____

Phone #: _____ Date of Birth: _____

Social Security #: _____ Email Address: _____

Medicare #: _____ Medicaid #: _____

Address: _____

City: _____ State: _____ Zip: _____

Personal Status:

☐ Married ☐ Divorced ☐ Single ☐ Widow/er ☐ Separated

Living Arrangements:

☐ With Relatives ☐ With Non-Relatives ☐ Alone ☐ Rest/Nursing Home ☐ Assisted Living

Members in Household:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Nearest Responsible Relative/Person:

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

Place of Employment: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

EMERGENCY CARE INFORMATION

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

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

Place of Employment: _____ Work Phone: _____

Cell Phone: _____

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

Place of Employment: _____ Work Phone: _____

Cell Phone: _____

EMERGENCY MEDICAL INFORMATION

Name of physician who will see you on request: _____

Address: _____ Phone: _____

Please list your hospital preference: _____

Please list Insurance information in the event of an emergency:

Insurance Company Name: _____ Insurance Policy Number: _____

ENROLLMENT

Attendance will be _____ days per week. Anticipated arrival/departure times: _____ / _____

Targeted days of attendance will be (please circle all that apply) ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S

I understand that participation in this program will be paid for by one of the following:

☐ Participant ☐ Relative ☐ Social Services ☐ Medicaid ☐ Other

Billing Address: _____

Transportation will be provided by: _____ Phone: _____

Others who may transport him/her are: _____

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 Total Life Center with and 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.

ASSISTANCE AND SUPPORTIVE DEVICES

Assistance may be required at the Total Life Center with the following Activities of Daily Living:

☐ Eating ☐ Dressing ☐ Ambulation ☐ Toileting ☐ Grooming ☐ Transferring

Supportive devices used by applicant:

☐ Cane ☐ Walker ☐ Wheelchair ☐ Hearing aid ☐ Dentures

☐ Eyeglasses (contacts) ☐ Other, please list: _____

Other services the applicant is currently receiving: _____

SERVICE PLAN DEVELOPMENT

Please list your personal concerns and knowledge of the applicant that may have an impact on the Service Plan the TLC will write.

I understand that within 30 days the program staff will conduct a comprehensive assessment of the applicant as he or she functions in the Total Life Center. During that time an individual Service Plan will be developed, with goals for the individual while in the program. The assessment and Service Plan will be updated every six months. Your input and assistance toward the plan is appreciated.

Signed: _____ Date: _____

Application administered / received by (signature) _____

Application administered / received on (date) _____