Enhancing Life Adult Day Center
10721 Tidewater Trail
Fredericksburg, VA 22408
PRE-ADMISSION FORM

How did you learn about our center:

____

APPLICANT INFORMATION

Name: ______________________________________
Address:_____________________________________
City: _______________________________________
State: ____________________ Zip: _____________
Phone Number: ______________________________
Please circle: **Single** **Married** **Divorced** **Widowed** **Separated**
Birth date: __________________ Age: ________
Social Security #: _________-_______-__________

PRIMARY CONTACT

1) Name: ___________________________________
Relationship: ______________________________
Address: __________________________________
City: _____________________________________
State: ___________ Zip Code: _______________
Phone Number: ______________________________
Work Number: ______________________________
Cell Phone: ________________________________
Email: _____________________________________

EMERGENCY CONTACTS

1) Name:_____________________________________
Relationship: ______________________________
Address: __________________________________
City: _____________________________________
State: ___________ Zip Code: _______________
Phone Number: ______________________________
Work Number: ______________________________
Cell Phone: ________________________________
Email: _____________________________________

2) Name:_____________________________________
Relationship: ______________________________
Address: __________________________________
City: _____________________________________
State: ___________ Zip Code: _______________
Phone Number: ______________________________
Work Number: ______________________________
Cell Phone: ________________________________
Email: _____________________________________

OTHER CARE BEING RECEIVED:

- ❏ Paid companion
- ❏ Therapies (OT,PT,Speech)___________
- ❏ Medicare Home Health
- ❏ Medicaid Personal Care

REASON SEEKING DAYCARE:
(checks all that apply)

- ❏ Family work
- ❏ Family respite
- ❏ Maintain maximum independence
- ❏ Become more independent
- ❏ Protection and supervision
- ❏ Continuous health monitoring
- ❏ Alternative to institutionalization
- ❏ Socialization
- ❏ Improved mental health

ATTENDANCE PREFERENCE (circle)**:**
Number of days per week: 1 2 3 4 5

Days of week: M T W TH F

Hours of attendance: _________ to _________

Physician name:_________________________________

Office phone number:___________________________

FINANCIAL OBLIGATION
Primary payment source (check one):

- ❏ Private pay
- ❏ CCCPlus Medicaid Waiver

Individual who will handle financial matters for applicant:
Name: ____

Address:

____

City: ____

State: ___________________ Zip: ___________________

Phone Number: __________________________________

Email address: ____________________________________

Is this person(circle): POA Legal Guardian Personal representative

Medicaid Applicants Only:

Medicaid No. __________________________________

Medicaid MCO and ID number:

- ❏ Aetna _________________________________
- ❏ Anthem _______________________________
- ❏ Virginia Premier _______________________
- ❏ Optima ________________________________
- ❏ United Healthcare ______________________
- ❏ Other: ________________________________

Please check one of the following:

- ❏ I agree to pay $_____ per hour for the time I attend Enhancing Life Adult Day Center
- ❏ Medicaid pays for my attendance at Enhancing Life Adult Day Care but I agree to pay my monthly patient pay required by Medicaid

  Current Patient pay amt. $_______________
  *subject to change at the discretion of Medicaid services

Signature:____
*applicant or financially responsible individual

Date:___________________________

Office use only:

Accepted:___________ Medical Forms:___________

Admitted:____________ Discharged: _____________