Northland
Adult Day Center LLC
1613 Swift Avenue North Kansas City, MO 64116
(816) 844-3955 - PHONE/FAX

PARTICIPANT APPLICATION

Name: _____Preferred Name: _____

Address: _____

City / State / Zip Code: _____

Home Phone: (____)_____-_____ Alternate Phone: (____)_____-_____

Email Address: _____

Gender: ☐ Male ☐ Female

Birth date:____/_____/_____ Age: _____

*Social Security Number: _____ - _____- _____

Primary Language: ☐ English Other Languages Spoken:_____

Highest Level of Education: ☐ Grade School ☐ High School ☐ College ☐ Other:_____

Previous Occupation: _____

Age at retirement: _____ Adjustment to retirement: ☐ good ☐ difficult

Are you a Veteran? ☐ No ☐ Yes
If yes, Branch: _____ Discharge/Retirement Date: _____

(Optional) Religion: _____

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

Preferred days/time for applicant to attend center:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time: _____a.m. to _____ p.m.

*This social security number will not be released except to medical personnel in an emergency.

INSURANCE INFORMATION

MO HealthNet (Medicaid)#: _____

Do you have a Medicaid Spenddown? ☐ No ☐ Yes, amount $_____

Medicare Claim# (Part A) Effective Date: _____

(Part B) Effective Date: _____

Private Insurance: _____

RESPONSIBLE PARTY INFORMATION

Name: _____Relationship to Client: _____

Address: _____

City / State / Zip Code: _____Home Phone: _____

Work Place: _____Work Phone: _____

Email address: _____Cell Phone: _____

Does primary caregiver live with the applicant? ☐ Yes ☐ No

If no, living arrangements: ☐ Lives alone ☐ Spouse ☐Relative ☐ Hired caregiver

☐ Other: _____

Is primary caregiver employed? ☐ Full time ☐ Part time

Does primary caregiver attend a support group? ☐ Yes ☐ No

Family goals for Day Care: ☐ Socialization ☐ Stimulation ☐ Family respite
☐ Supervision Other: _____

MEDICAL INFORMATION

Doctor's Name: _____Specialty _____

Address: _____

Phone Number: ( ) _____ Fax: ( )_____

Hospital Preference: _____

Has applicant completed the following: ☐ Durable Power of Attorney
☐ Do Not Resuscitate Order

Will the applicant require assistance with medication while at the Center? ☐ Yes ☐ No

TRANSPORTATION / REFERAL INFORMATION

How will applicant be transported to/from center?
- ☐ Share-A-Fare/RideKC
- ☐ Assisted Transportation
- ☐ Center Transportation Service
- ☐ Self
- ☐ Caregiver/Family

How was the caregiver referred to this program?
☐ DHSS/Dept. of Senior Services ☐ Veteran's Administration ☐ Relative/Friend
☐ Alzheimer's Organization ☐ Other _____

LEGAL GUARDIANSHIP INFORMATION

Does applicant have a Legal Guardian? If so, please complete information below.

Name_____

Address_____

Phone ( ) _____ cell ( ) _____ Work ( )_____

EMERGENCY CONTACTS AND PERSONS AUTHORIZED TO TRANSPORT PARTICIPANT

(other than primary caregiver)

Name_____

Address_____

Phone ( ) _____ cell ( ) _____ Work ( )_____

Email_____

Relationship to Client _____

Name_____

Address_____

Phone ( ) _____ cell ( ) _____ Work ( )_____

Email_____

Relationship to Client _____

Name_____

Address_____

Phone ( ) _____ cell ( ) _____ Work ( )_____

Email_____

Relationship to Client _____