



ADMISSIONS APPLICATION

Name: _____ Telephone: _____

DO: _____ Readmission: Yes No Former No: _____

Present Address: _____

Date of Birth: _____ Marital Status: _____ Religion: _____

Physician: _____ Address: _____

Physician Telephone: _____ Hospital Preference: _____

Social Security Number: _____ Payor Source: _____

Medicaid #: _____ MLTC/MMC and contact: _____

Transportation: _____ Days Scheduled: _____ Hours Per Day: _____

Present Living Arrangements: _____

Diagnosis: _____

Allergies: _____ Diet: _____

Reason for Application: _____

Referred by: _____ Other Agency Served by: _____

Home Health/Service Coordination/Case Management: _____

PERSON(S) TO BE NOTIFIED IN CASE OF EMERGENCY:

1. Name: _____ Relationship: _____

Circle if applicable: Health Care Proxy Power of Attorney

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. Name: _____ Relationship: _____

Circle if applicable: Health Care Proxy Power of Attorney

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

In compliance with New York State and Federal Laws, which prohibit discrimination, based on race, creed, color, sex, national origin, disability, blindness, marital status, sponsorship or source of payment, this facility admits and treats all registrants on a non-discriminatory basis.

According to the best of my knowledge and belief, the foregoing information is accurate and true in all respects. The undersigned agrees to notify Golden Days of any change in the applicant's financial condition. I agree, if admitted, to abide by the regulations of Golden Days Adult Day Health Care.

Signature of Registrant or Responsible Party

Date