APPLICATION

Rogerson Egleston Adult Day Health Program
2053 R Columbus Ave.
Roxbury, MA 02119
617 427-5505 Fax: 617 427-5544

Date:_______________

Name:____ Phone: ________________________________

Address:____
Street Apt. City Zip

Male: _____ Female: _____ Live Alone: Yes:_____ No:_____ With:________________ Relationship:__________

Social Security #: _________________ Date of Birth:___________________ Marital Status: M S W D

Referred by: __________________________________ Phone:_____________________________________

Relationship: ____

Reason for Referral: ____

____

____

Primary Physician: __________________________ Phone: _________________ Fax ____________________.

Address: ____

Primary Nurse: ____________________________ Agency:_______________ Phone:__________________

Hospital Affiliation: ___________________________________ Clinic: _______________________________

Case Manager:___________________________ Agency: _______________________ Phone: _______________

Do you have a Visiting Nurse?

Name:________________________________Agency:_______________________________________Hrs & Days:

Do you have a Home Health Aid/Homemaker?

Name:________________________________Agency:_______________________________________Hrs & Days:

Have you been hospitalized in the last 2 years? When? Where? Why?

____

Have you been in a long-term care facility? Where and When?

Chronic Hospital:_____________________________ Level I/II Nursing Home:___________________________

Rehabilitation Facility __________________________ Level III Nursing Home:___________________________

Mental Health Facility:_________________________ Rest Home:______________________________________

Do you receive any other services?

Name:____ Agency:____

Contact Person:______________________________ Phone:____

What hobbies, crafts, interests, educational desires, clubs do you like?

____

____

____

Former Occupation:______________________________ Religion: ___________________________

Where were you born? ____________________________What languages do you speak? ___________

How much school did you have? ____

Please comment on social history or any other pertinent information.

____

____

____

____

Transportation: Family: ________ Chair Car:__________ Program Van:____________

Other:_____________________

Source of Payment: This section must be fully completed or admission will be delayed.

Insurance:

Medicaid Card #__________________________ Medicare ________________________ A B

Medicaid ID # ___________________________ Medex _________________________ 1 2 3

Category of Assistance: ____________________

DMA Caseworker: __________________________ Phone: ______________________

Self Pay: __________________________________ Other:____________________________________

Responsible Person (s): **(Important to fill out completely)**

Name:________________________________ Phone: Home: ______________ Work: _______________

Address:____ Relationship:_____________________

Name:________________________________ Phone: Home: ______________ Work: _______________

Address:____ Relationship:_____________________

Name:________________________________ Phone: Home: ______________ Work: _______________

Address:____ Relationship:_____________________