



Adult Day Care & Adult Day Health Programs Managed by Arcadia Elder Services

CUC Adult Day Care & Day Health Center

Kilohana Adult Day Care Center

APPLICATION FOR ADMISSION

APPLICATION DATE: _____

NAME _____
LAST FIRST MIDDLE

MAILING ADDRESS _____
NUMBER/STREET CITY STATE ZIP

PHONE _____ MARITAL STATUS S M W D ETHNICITY _____

PRESENTLY LIVES WITH _____ RELATIONSHIP _____

DATE OF BIRTH _____ AGE _____ SEX _____ RELIGION _____

OCCUPATION _____

CONTACT PERSON _____ BUS _____ RES _____

ADDRESS _____
NUMBER/STREET CITY STATE ZIP

ALTERNATE CONTACT PERSON _____ BUS _____ RES _____

ADDRESS _____
NUMBER/STREET CITY STATE ZIP

REFERRED BY/FROM _____
INDIVIDUAL/AGENCY/SOCIETY

DAY SERVICES REQUESTED: MONDAY TUESDAY WEDNESDAY THURSDAY
FRIDAY SATURDAY

PHYSICIAN'S NAME _____

PHYSICIAN'S PHONE _____

HOSPITAL PREFERENCE IN EMERGENCIES _____

RESPONSIBLE PERSON'S SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

____ PE COMPLETED INTERVIEW/EVALUATION DATE _____ REVIEW DATE _____
____ TB CLEARANCE OTHER INFORMATION REQUIRED _____
____ DIET ORDER START DATE _____ OR REASON REFUSED _____

ASSESSMENT BY: _____