West Tennessee HEALTHCARE™
Therapy & Learning Center ADULT DAY SERVICES

ADULT DAY SERVICES APPLICATION

Name:_______________________________________ Date:______________________

Address:____

City:__________________________ State:______________ Zip:_________________

Home Phone:___________________________ Alt. Phone:______________________

Date of Birth:_________________ Social Security Number:______________________

Does the participant live: _____At home alone/with a caregiver
_____In a Supported Living/Assisted Living home

Primary Diagnosis:____

Descriptive Information

Height:_______________ Weight:_______________ Sex: M F

Competency Status: *circle which applies* Competent Incompetent

Parent / Conservator Information

Name(s):____

Address: (indicate if same as above)____

City:_________________________________ State:_________ Zip:_______________

Home Phone:________________________ Work Phone:________________________

Cell Phone:_______________________ Cell Phone Carrier:______________________

Email Address:____

First Emergency Contact

Name:____

Relationship to participant:_______________________ Phone:___________________

Second Emergency Contact

Name:____

Relationship to participant:_______________________ Phone:___________________

Medical History

1. ____Measles: Mild____ Moderate____ Severe____
2. ____Mumps: Mild____ Moderate____ Severe____
3. ____Whooping Cough: Mild____ Moderate____ Severe____
4. ____Chicken Pox: Mild____ Moderate____ Severe____
5. ____Encephalitis: Mild____ Moderate____ Severe____
6. ____Meningitis: Mild____ Moderate____ Severe____

Where were immunizations received?____

Has applicant ever had a seizure? Yes____ No____ **If Yes, please indicate at what age seizures began.**____

Does applicant continue to have seizures? Yes____ No____ **If Yes, how frequent have these been?**____

Does the applicant require mobility equipment/specialized appliances? (Ex: wheelchair)

Yes____ No____ **If Yes, please list type and purpose.**_________________________

Please indicate any drug allergies:____

Other allergies:____

Does the applicant have a history of alcohol and/or drug abuse? Yes____ No____

If Yes, please describe treatment received.____________________________________

Physician Information

Name:_______________________________________ Phone:______________________

Clinic / Hospital:____

Address:__________________________ City:__________ State:______ Zip:________

Participant's Name:_________________________________

Medical Information

Other Disabilities / Diagnoses:____

Allergies: (food, drug, etc.)____

Medication History of Applicant (Include both prescription and any over the counter medication) ****use the back of this page if more room is needed***

THERAPY & LEARNING CENTER WILL ONLY ADMINISTER MEDICATIONS THAT ARE PRESCRIBED MORE THAN 2X PER DAY.

Drug	Dose	Doctor	Reason	Date Started

Other Specialists

Name:_____________________________________ Phone:____________________

Clinic / Hospital:____

Address:___________________________ City:__________ State:______ Zip:________

Reviewed: 06.02.2020

CHOICES Care Coordinator

Name:____

Agency:____

Address:____

City:______________________________ State:__________ Zip:______________

Phone Numbers:____

Other Services Received (if applicable)

Name:____

Agency:____

Address:____

City:______________________________ State:__________ Zip:______________

Phone Numbers:____

Insurance Information

Primary Insurance:_________________________ Phone:___________________

Subscriber/ID#:__________________________ Group/Policy#:_______________

Name of Card Holder:____

Card Holder DOB:__________________________ Effective Date:______________

Secondary Insurance: _______________________ Phone:___________________

Subscriber/ID#:___________________________ Group/Policy#:______________

Name of Card Holder:____

Card Holder DOB:_____________________ Effective Date:__________________

Medicaid Number:____

****COPY OF INSURANCE CARD SHOULD BE SENT ALONG WITH THIS PACKET**

Financial Information

Who is Representative Payee?____

____ ________________

Participant/Conservator/Caregiver Signature Date