Application for Adult Day Services

Tel Hai Retirement Community
2200 Tel Hai Circle – PO Box 190
Honey Brook, PA 19344
Phone: 610/273-9333 ext. 2030; 610/273-4619
Lakeview Personal Care Fax: 610/273-4151

$250.00
Refundable
Security Deposit

PERSONAL INFORMATION:

Name	
Preferred Name	
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	

Birth Date		Social Security #					
Sex		Height		Weight		Eye Color	
Language Spoken							
Identifying Characteristics							
Marital Status	Married	Widowed	Single	Divorced			
Spouse's Name							

INSURANCE INFORMATION:

Medicare #	
Supplemental Insurance Co.	
Supplemental ID #	
Managed Care Insurance Co.	
Managed Care ID #	

ADDITIONAL INFORMATION:

Physician	
Hospital Preference	
Ambulance Company	

BILLING INFORMATION:

Name	
Relationship	POA Spouse Child Grandchild Legal Rep/Other
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Work Phone	
Email	

AUTHORIZED EMERGENCY CONTACTS/RESPONSIBLE PARTY TO ACT ON CLIENTS BEHALF:

Name	
Relationship	POA Spouse Child Grandchild Legal Rep/Other
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Work Phone	
Email	

Name	
Relationship	POA Spouse Child Grandchild Legal Rep/Other
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Work Phone	
Email	

Attachments required at the time of submission of this application:

- ☐ **Signed & dated Application**
- ☐ Photocopy of Power of Attorney
- ☐ Photocopy of Living Will and/or Advanced Directives
- ☐ Photocopy of Photo ID
- ☐ Photocopy of front and back of health insurance cards, social security card & Medicare card

Please answer the following questions.

Living Arrangements	House Apartment Modular Home Other
Length of Time at Present Address	10+ years 5-10 years 1-5 years less than 1 year
Means of Transportation (check all which apply)	Private Public Rover Other
Types of Outside Assistance Being Utilized (check all which apply)	Office of Aging Veteran's Com MH/MR Meals on Wheels Support Groups Church/Pastor Friend/Neighbor Therapy Services
On a scale of 1-10, 10 being the highest degree, please indicate:	Stress as a caregiver Degree of problems as a caregiver Need for outside assistance Limitations placed caregiver
Need for Supervision (indicate one)	May be left alone for: Never 5 Minutes or less Half Hour Hour+

I do hereby certify that the information listed is true and complete to the best of my knowledge.

Date:	Signature: