Hebrew Rehabilitation Center
Hebrew SeniorLife

Hebrew Rehabilitation Center
1200 Centre Street
Boston, Massachusetts 02131
Tel: 617-363-8515
Fax: 617-363-8516 * NEW
www.hebrewseniorlife.org

For Office Use Only
Acct. #:
MR #:
Adm. Date:
D/C Date:

GREAT DAYS FOR SENIORS

Adult Day Health Program

APPLICATION FORM (Please **PRINT** and fill out form completely.)

Name _____ ☐M ☐F
Last First M.I. Maiden

Address_____
Number Street Apt. #

_____
City State Zip

Telephone # (_____)_____-_____ **Social Security #** _____/_____/_____

Religion _____ **Primary Language**_____

Ethnicity: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other

Date of Birth _____/_____/_____ **Birthplace** _____**U.S. Citizen**: ☐YES ☐ NO
MM DD YYYY

Marital Status _____ **Name of Spouse** _____

In the Event of Medical Emergency

The Adult Day Health Program will arrange for emergency medical care and transport to the hospital that is indicated below. If the identified hospital will cause unreasonable delay, the ambulance team reserves the right to transport to a closer facility.

Please list the hospital with which your primary care physician is affiliated: _____

I have read and agree to the above plan.

_____ _____
Participant or Responsible Caregiver Date

For Office Use Only: Primary Diagnosis _____

Please list the names and addresses of people whom you want us to contact for ongoing information and in case of emergency. Please include seasonal addresses and telephone numbers, if applicable.

Contact #1

Name □**Mr.** □**Mrs.** □**Ms.** □**Miss.**_____
First Last

Address_____
Number Street Apt. #

_____
City State Zip

Relationship_____

Home (_____) _____ - _____ **Work** (_____) _____ - _____ **ext** _____ **Fax** (_____) _____ - _____

Cell (_____) _____ - _____ **E-Mail** _____

Contact #2

Name □**Mr.** □**Mrs.** □**Ms.** □**Miss.**_____
First Last

Address_____
Number Street Apt. #

_____
City State Zip

Relationship_____

Home (_____) _____ - _____ **Work** (_____) _____ - _____ **ext** _____ **Fax** (_____) _____ - _____

Cell (_____) _____ - _____ **E-Mail** _____

Contact #3

Name □**Mr.** □**Mrs.** □**Ms.** □**Miss.**_____
First Last

Address_____
Number Street Apt. #

_____
City State Zip

Relationship_____

Home (_____) _____ - _____ **Work** (_____) _____ - _____ **ext** _____ **Fax** (_____) _____ - _____

Cell (_____) _____ - _____ **E-Mail** _____

Please list the services you are currently receiving:

Service	Name of Agency	Contact Person	Phone	Frequency
Visiting Nurse				
Home Health Aide, Personal Care Asst.				
Homemaker				
Adult Day Health				
Meals on Wheels				
Other (PT, OT, Social Worker etc.)				

Please provide COMPLETE name, address & telephone # for all physicians:

Name	Specialty	Address/Zip	Telephone #
	Primary Care Physician		

Do you have a pacemaker? Yes___No___ If yes, please indicate the physician managing your pacemaker:

Physician Name	Address/Zip	Telephone #

Please list any hospital admissions you have had in the past 3 years (including psychiatric and nursing home admissions):

Hospital	Date	Reason

Advanced Directives and Legal Representatives: Please indicate if you have any of the following.

Do Not Resuscitate Order Yes_____ No_____	If yes, please give us a copy of the Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) form.
Health Care Proxy (please provide a copy)	Name_____ Alternate_____
Guardian (please provide a copy)	Name:
Conservator	Name:
Durable Power of Attorney	Name:
Power of Attorney	Name:

Payment Options for the Adult Day Health Program: Please indicate if you are affiliated with any of the following agencies, so we can determine your payment options.

Massachusetts Medicaid information

Mass Health #: _____ **(**Please submit a copy of your MassHealth card.)

I am a member of a MassHealth Senior Care Organization:

Commonwealth Care Alliance_____ Senior Whole Health_____ UnitedHealthcare_____

I am not already enrolled, but I believe I may be eligible for MassHealth/Medicaid: YES ____ NO ____

I have filed a Medicaid application and am awaiting the determination: YES ____ NO ____

Do you receive services from one of the following state Elder Service Agencies?

Boston Senior Home Care ____ Central Boston Elder Services ____ Ethos ____

HESSCO ____ South Shore Elder Services ____ Springwell ____

Are you a U.S. Veteran? YES _____ NO _____

Do you receive medical care through the VA Boston Healthcare System? YES _____ NO _____

Other Health Insurance Information (Please submit copies of all health insurance cards.)

Medicare # _____

Do you have Hospital Insurance/ Part A? YES_____ NO_____ Effective Date: _____
Do you have Medical Insurance/ Part B? YES_____ NO_____ Effective Date: _____
Do you have a Managed Care Plan? YES_____ NO_____ Enrollment Date:_____
Name of Managed Care Plan:_____

If you are not eligible for Medicare, please explain: _____

_____

Medigap/Medex Insurance/ Other Supplemental/Commercial Insurance:

Plan: _____ Policy #: _____

Company Name and Address (i.e., Blue Cross of Massachusetts):_____

Name of insured (patient or spouse): _____

Is your plan an HMO (Health Maintenance Organization)? YES____ NO____