



**APPLICATION FOR ADMISSION**

Date of Application: \_\_\_\_\_ Applicant Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_  
Last First MI

Present Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_

Billing Address:  Same as above

\_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Living Situation:  Alone  With Family—Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Long Term Care Residence/Community

Independent Living  Assisted Living  Nursing Home

Name of LTC Residence: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Marital Status: \_\_\_\_ Religious Faith: \_\_\_\_\_ Place of Worship: \_\_\_\_\_

*This information is requested for government statistical reporting purposes only. It will not affect your admission to Keswick:*

Race/Ethnic Origin: \_\_\_\_\_ Gender: M F

Highest Level of Education: \_\_\_\_\_

*Keswick accepts clients, provides services, and operates its facilities without discrimination on the basis of race, national origin, religion, marital status, age, sex or disability.*

Legal:

Durable POA for Healthcare?  Yes  No HCPOA: \_\_\_\_\_

Durable Financial Power of Attorney?  Yes  No Name of DPOA: \_\_\_\_\_

Living Will?  Yes  No Other Legal: \_\_\_\_\_

Enrolled in Safe Return/Medic Alert Program:  Yes  No \_\_\_\_\_

Emergency/Key Contacts

<u>Name</u>	<u>Relationship</u>	<u>Contact Phone Number:</u>

- Please turn over to complete additional information



# KESWICK

Adult Day Services

Insurance Information:

Medicare ID Number: \_\_\_\_\_ Part A  Part B

Medigap Insurance Co: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Medicaid: \_\_\_\_\_ Waiver program \_\_\_\_\_

Long Term Care Insurance Co: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Veteran:  Yes  No Enrolled in VA Adult Day Program Benefit:  Yes  No \_\_\_\_\_

Other Insurance Information: \_\_\_\_\_

\*\*\*\*Please give a copy of *all* your medical insurance cards.

To better serve you and your family:

Why are you seeking an adult day program?

- Activities
- Respite
- Supervision

- Medication oversight
- Assistance with dressing, bathing, eating, etc.
- Other: \_\_\_\_\_

What service(s) do you need from an adult day program?

- Transportation to/from the program
- Religious services
- Day trips
- Activities focused on physical exercise

- Activities which are dementia-specific
- Financial assistance
- Other: \_\_\_\_\_

How did you hear about Keswick Adult Day Services?

- Physician  
Please specify:  
\_\_\_\_\_

- Alzheimer's Association
- Conference/Educational Seminar  
Please specify:  
\_\_\_\_\_

- Support Group
- Website
- Phonebook
- Current/Past Keswick Participant
- Walk-in
- Other: \_\_\_\_\_

**Return completed application by mail or fax:**

Keswick Adult Day Services, 700 W. 40<sup>th</sup> St. Baltimore, MD 21211  
410.662.4328 (fax)

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Keswick Only

- Copy of insurance cards