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SAINT ELIZABETH
ADULT DAY CENTERS
Member of Saint Elizabeth Community
Trusted Care Since 1882

Application for Admission

☐ **Memory Care Center** ☐ **Apponaug Center** ☐ **Bristol Center** ☐ **South Kingstown**

Applicant Information

Name:_____

Address:_____City:_____ State:_____Zip:_____

Phone:_____Cell:_____

Date of Birth:_____Sex: Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

With whom does applicant live: ☐ Alone ☐ Spouse ☐ Adult Child ☐ Group Home ☐ Other

Reason for application:_____

Days needed: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Unsure

Needs assistance with: ☐ Walking ☐ Toileting ☐ Bathing ☐ Eating ☐ Other

Does applicant have memory impairment? ☐ Yes ☐ No

What special needs does the applicant have? (i.e., need for socialization, supervision, etc.)_____

_____

Primary Care Physician Name:

Caregiver Information

#1. Caregiver Name:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Cell:_____

Relationship:_____

#2. Caregiver Name:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Cell:_____

Relationship:_____

Person completing this form: ☐ Caregiver #1 ☐ Caregiver #2 ☐ Other

If other, please note name, relationship and phone number:_____

_____