*The Harry and Jeanette Weinberg Campus of Seagull Schools, Inc.*
*531 Farrington Hwy., Kapolei, Hawaii 96707 Phone: 674-1160 Fax: 674-1167*

# ADULT DAY CARE APPLICATION

**TODAY'S DATE____/____/____**

NAME _____
Last First Middle Preferred

ADDRESS _____
Street City Zip Code

PHONE _____ MARITAL STATUS _____ SPOUSE NAME _____

LIVING WITH (NAME) _____ RELATIONSHIP _____

SEX _____ BIRTHDATE ____/____/____ BIRTHPLACE _____

ETHNICITY _____ LANGUAGE(S) SPOKEN _____

YEARS OF EDUCATION _____ RELIGION/CHURCH _____

FORMER OCCUPATION _____

NUMBER OF: ____ SONS ____ DAUGHTERS ____ LIV. SIBLINGS ____ GRANDCHILDREN ____ GREAT GRANDCHILD

**CAREGIVERS** – Please list primary caregiver first (If additional space is needed, attach sheet to application.)

1. Name Name _____ Relationship _____
   Address _____ Phone _____
   Email _____ Other Phone _____
2. Name _____ Relationship _____
   Address _____ Phone _____

**PERSON(S)/AGENCY RESPONSIBLE FOR PAYMENT** (If additional space is needed, attach sheet to application.)

1. Name _____ Relationship _____
   Address _____ Phone _____
   Email _____ Other Phone _____
2. Name _____ Relationship _____
   Address _____ Phone _____

**MEDICAL INFORMATION** ____ OHANA ____ UNITED HEALTH ____ OTHER _____

MEDICAID #_____ MEDICAID ACCSB WORKER _____ PHONE_____

DATE OF LAST PHYSICIAN'S APPOINTMENT PRIOR TO PHYSICAL _____

LAST HOSPITALIZATION _____ WHAT REASON _____

PHYSICIAN'S NAME _____ PHONE _____

ADDRESS _____

I and/or We, the undersigned, client/caregiver/guardian of _____do hereby authorize Seagull
Client's name
Schools, Inc. as an agent(s) for the undersigned to consent to emergency treatment by another physician and/or surgeon licensed in the State of Hawaii, when the undersigned's regular physician cannot be contacted. _____

WEARS GLASSES_____ HEARING AID_____ READS_____ WRITES_____ **Signature of Client or Caregiver/Guardian**

ORIENTATION TO PERSON_____ PLACE_____ TIME_____

**LEGAL ASSESSMENT**

DURABLE POWER OF ATTORNEY – HELD BY _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS: _____

LEGAL GUARDIAN OF PERSON: _____ OF PROPERTY: _____

IS LIVING WILL OR DPOA FOR HEALTHCARE ON FILE WITH ADC? YES: _____ NO: _____

**TRANSPORTATION**: Please check the appropriate box for morning drop off and afternoon pick-up

AM: PRIVATE _____ HANDIVAN _____ PASS# _____ OTHER _____

PM: PRIVATE _____ HANDIVAN _____ PASS# _____ OTHER _____

**ATTENDANCE: REQUESTED START DATE IS _____**

Please indicate the days and approximate times of attendance

MONDAY _____ A.M. - _____ P.M. TUESDAY _____ A.M. - _____ P.M. WEDNESDAY _____ A.M. - _____ P.M.

THURSDAY _____ A.M. - _____ P.M. FRIDAY _____ A.M. - _____ P.M. SATURDAY _____ A.M. - _____ P.M.

**I UNDERSTAND I WILL BE CONTACTED WHEN THERE IS A SPACE AVAILABLE.**

**CONTACT PERSON** _____ **PHONE** _____

**SIGNATURE** _____ **DATE** _____

| *FOR OFFICE USE ONLY* | | | *DATE* | *CHK/REF#* | *AMOUNT* | *INITIAL* |
|---|---|---|---|---|---|---|
| *ASSESSMENT DATE* | *PRIVATE / MEDICAID* | *REGISTRATION FEE* | | | *$* | |
| *START DATE* | *LEVEL OF CARE* | *TUITION FEE* | | | *$* | |