

# The Next Step Adult Day Program and Wellness Center

## Program Application

Date of Application: \_\_\_\_\_ Referred by: \_\_\_\_\_

Desired Program:

Day Program  Apartment with Services  ILS

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Does the applicant live:  Independent  With Spouse/family  Group/foster

Group/Foster Home Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ MA/Medicare number: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternate phone number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternate phone number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternate phone number: \_\_\_\_\_

Social Worker: \_\_\_\_\_ County: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ email: \_\_\_\_\_

Waiver:  CADI  TBI  Elderly  Private pay

Marital Status:  Married  Divorced  Widowed  Single

Spouse's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Religious Preference: \_\_\_\_\_

Living Will: \_\_\_\_\_ DNR Order (if yes, please attach copy): \_\_\_\_\_

# The Next Step Adult Day Program and Wellness Center

Physician's Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternate phone number: \_\_\_\_\_

Release of Information to obtain medical records for past year:  Yes  No

Initials \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Date of last Mantoux test or chest x-ray (must be within past 3 months): \_\_\_\_\_

Allergies: \_\_\_\_\_

Hearing:  Good  Impaired  Hearing Aids  Deaf

Vision:  Good  Impaired  Glasses  Blind

Ambulation:  Self  Cane/walker  Wheelchair  other

Toileting:  Self  Needs assistance  Wears protective garment

Personal Hygiene:  Self  Needs assistance  Other

Self Preservation:  Yes  No

Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diet Restrictions: \_\_\_\_\_

Diabetic: \_\_\_\_\_ Insulin Dependant: \_\_\_\_\_

Current Transportation: \_\_\_\_\_

Would you be interested in using our transportation services? \_\_\_\_\_

## The Next Step Adult Day Program and Wellness Center

Please provide the most information that you can accurately. This information will benefit you and your progress throughout your time with this program. Please inform the Program Director of any mistakes or changes that need to be made.

I verify that all of the information provided is correct to the best of my knowledge.

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian

\_\_\_\_\_  
Date

***The Next Step Adult Day Program and Wellness Center reserves the right to deny acceptance into this program for reasons determined by the Owner or Program Director.***

**Please return to:**

The Next Step Adult Day Program  
2424 75<sup>th</sup> Street NW #4  
Rochester, MN 55901  
Fax: 507-282-7717

**For office use only**

\_\_\_\_\_  
Date received

\_\_\_\_\_  
Date of intake

\_\_\_\_\_  
Program Director

Day Program/ILS:  
Approved amount of days per week: \_\_\_\_\_ Per \_\_\_\_\_

Scheduled days of attendance:  
 Monday    Tuesday    Wednesday    Thursday    Friday