RIVERWALK ADULT DAY SERVICES

Intake Information

Client Information

Intake Date: _____ Start Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Sex: _____ Marital Status: _____ Religion: _____ Veteran? _____

Physician: _____ Phone: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Hospital Preference:_____ Name of person participant lives with: _____

Caregiver and Family Information

Caregiver's Name: _____ Phone: _____

Caregiver's Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Is there a Do Not Resuscitate order: _____

Is there a Power of Attorney (if so, who): _____

Additional Contact: _____ Phone: _____

Additional Contact: _____ Phone: _____

Children: _____ City, State: _____

Children: _____ City, State: _____

Children: _____ City, State: _____

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Intake Information Cont.

Transportation and Payment Information

Transportation- Who will be responsible for: _____

Responsible Party for Billing: _____

Address: _____

City: _____ State: _____ Zip: _____

Notes: _____

Information for Grant Applications

The information below is optional but will help Riverwalk Adult Day Services apply for grants and donations. This information will never be shared with any other person or organization.

Participant's Race: _____ Female Headed Household? **Y** **N**

Participant Monthly Income: _____ Household Income: _____

Office Use Only

Staff: _____ Date: _____