APPLICATION FOR ENROLLMENT
Coltrane L.I.F.E. Center, Inc.
Concord, NC 28025

Applicant's full name: _________________________________ **Date of Birth:** ______________ **Gender:** ______

Address: ____**County:** ________________

Telephone: ______________________________ **Social Security Number:** _______________________________

Medicare Number: ________________________ **Medicaid Number:** ___________________________________

Why is applicant interested in coming to this program? ____
____

Has he or she had previous experience in a day program? YES ____ NO ____

If yes, where and when: ____

Ethnicity: ___**Caucasian Non-Latino** ___**African American** ___**Latino/Hispanic** ___**Asian**
___**Native American** ____**Other:**__________________ **Nationality**______________________________

Marital Status: ___ **Married** ___ **Single** ___ **Widowed** ___ **Divorced**

Living Arrangements:___**With Relatives** ___**Non-Relatives** ____ **Alone in House/Apartment/Single Room**

Living With Whom: ____________________________________ **Relationship:**_____________________________

Nearest Responsible Relative: _____________________________ **Relationship:**____________________________

Relative's Home Address: ____**Home phone:**____________________

If relative is employed, where: _____________________________________ **Business Telephone** _____________

<u>EMERGENCY CARE INFORMATION</u>

Please list the names of <u>at least two</u> persons who may be contacted in case of emergency:

(1)____ ____
Name & Relationship to Applicant **E-Mail Address**
____ ______________________/_______________________
Address/Zip **Home phone** **Cell/Work phone**-<u>please circle</u>

(2)____ ____
Name & Relationship to Applicant **E-Mail Address**
____ ______________________/_______________________
Address/Zip **Home phone** **Cell/Work phone**-<u>please circle</u>

(3)____ ____
Name & Relationship to Applicant **E-Mail Address**
____ ______________________/_______________________
Address/Zip **Home phone** **Cell/Work phone**-please circle

____

Why is the family interested in the applicant coming to Coltrane LIFE Center?___________________________

____

How would you like the applicant to benefit from the program?____

____

Name of Physician who will see applicant on request: ________________________ Phone __________________

Physician's Address:____

Name of Dentist: ____Phone _________________________

Transportation will be provided by: ____ Relative/Friend: ____
____ Public Transportation
____ Coltrane L.I.F.E. Center

Arrival Time: _____________ Departure Time: _______________

Any special dietary needs? ____

Days of Attendance: Monday Tuesday Wednesday Thursday Friday
(Circle days of attendance)

Does the applicant currently take medication during the day? Yes_____ No_____
(If participant takes medication during the day, NC regulations require that you bring the medicine in the original pharmacy bottle.)

Are any caregivers or family members employed by any of the following companies? If so, please check next to the company and list the family member's name and relationship to the applicant.
(This is information requested by United Way and other funding sources.)
____Bank of America____
____B F Goodrich____
____Carolinas HealthCare Systems/Atrium____
____Duke Energy Corporation____
____Wells Fargo ____
____IBM____
____Microsoft____
____UPS____

<u>REQUIRED</u>

Does the applicant have a Do Not Resuscitate Order? Yes_____ No_____
(If yes, please provide original yellow form signed by Doctor for our files at the Center)

If emergency medical care becomes necessary, I give permission for any treatment the physician deems necessary.

SIGNATURE: ____Date:_________________________
Applicant or Responsible Party

Coltrane LIFE Center's program policies have been explained to me, and I have been given a copy of the Policy Statement.

I understand that participation in this program will be paid for by:

___Myself ___Scholarship ___CAP ___VA ___DSS ____Family Caregiver Program
Other:____

If applying for assistance:
Monthly income: Participant: $__________ Spouse: $___________

Checking Account: ___ Amount in Checking Account: $ __________________

Savings Account: ___ Amount in Savings: $ __________________

Bill should be sent to: ____
Name

____
Address (if not listed above)

DATE: __________________ SIGNATURE: ____
Applicant or Responsible Party

I give permission for photographs, video, audio recordings or slides to be made and used by Coltrane L.I.F.E. Center in materials (newsletters, website, brochures, Facebook, etc.) in any constructive way possible to benefit and inform others. In granting this permission, I hereby waive any and all causes of action that might otherwise occur from the exhibition that might be made of same.

DATE___________________ SIGNATURE: ____
Applicant or Responsible Party

PLEASE SUBMIT APPLICATION ALONG WITH A
$25.00 APPLICATION FEE*

TO:

COLTRANE L.I.F.E. CENTER, INC.
321 Corban Ave., SE
Concord, NC 28025

*Application fee may be waived based on available funding source.

<u>PLEASE LABEL ALL CLOTHING AND SUPPORTIVE DEVICES SUCH AS CANES, WALKERS, WHEELCHAIRS WITH THE PARTICIPANT'S NAME</u>

Over-→

Applicant's NAME____

In order to better serve your family member it is helpful for staff to have some family history and information that will help us to relate to him or her more effectively.

Location applicant grew up:____

Number of Brothers:______ Sisters:______ Highest grade completed: ______

Former occupation/work:____

Current or previous hobbies/clubs/interest:____
(please circle currently or previously)
Currently or previously active in church: Yes:_____No:_____Denomination:______________________________

Name of applicant's church: (if applicable)____

Church Address____

Number of children:____Names:____

Number of grandchildren:__________ **Number of great grandchildren:_________**

Is applicant a veteran? ____Yes ____No Branch of Military Services:________________________________

Served in war? ____Yes ____No Which one(s):____

Language other than English:____

Can your family member carry out the following activities <u>without help or prompting?</u>
(please circle yes or no)

Eat—Yes No
Get dressed—Yes No
Bathe self—Yes No
Use the toilet—Yes No
Transfer into/out of bed/chair—Yes No
Walk—without help—Yes No
Uses walker or cane—Yes No
Uses wheelchair—Yes No
Prepare meals—Yes No
Shop for personal items—Yes No
Manage own medications—Yes No
Manage own money— Yes No
Use the telephone—Yes No
Do heavy cleaning—Yes No
Do light cleaning—Yes No
Has interaction with friends—Yes No

Is it safe for the applicant to be left alone? Yes No
Does the applicant enjoy being with other people? Yes No
Is the applicant socially isolated? Yes No
Does the applicant have certain activities he/she enjoys? Yes No; If yes, please list___________________

____

Does the applicant have confusion? Not at all Part of the time Most of the time

Additional information important to know about the applicant____
____