MAI VANG Day Care Center

Application of Services

9525 Wilcrest Drive, Houston, TX 77099
Tel: 346-312-5728 or Direct: 832-794-2100
Website: www.sunriseactivity.com

GENERAL INFORMATION

Name of Applicant: _____ _____ _____
Last Name First Name Middle Name

Present Address:

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number:

Home: _____ Cell: _____

Date of Birth: _____ Social Security Number: _____

Marital Status (Please Check) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Language (Please Check) ☐ English ☐ Spanish ☐ Other; Specify _____

Communication Mode (Please Check) ☐ Verbal ☐ Gestures ☐ Vocalizations ☐ Sign Language ☐ Device(s) Specify _____

GENERAL PROGRAM INFORMATION

Days requesting attendance (Please circle all that applies) ☐ M ☐ T ☐ W ☐ TH ☐ F

Time Requesting Attendance: Start Time: _____ End Time: _____

Transportation to and from Day Care: (Please Check)

☐ Personal ☐ Metrolift ☐ Program Transport

Participating Meals (Please Check all that applies)

☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Dinner

BACKGROUND INFORMATION

Place of Birth: City: _____ County: _____ State: _____

US Citizenship (Please Check) ◯ Yes ◯ No Ethnicity: _____ Religion: _____

Legal Status (Please Check) ☐ Competent ☐ Incapacitated (Court Appointed Guard)

If has a Guardian:

Name of Guardian: _____

Realationship to Applicant: _____

INSURANCE INFORMATION

Medicaid (Please Check):

◯ Y, Number (#) _____

◯ N, Have applied and been denied

◯ NM, Have never applied

Other Sources (Please Check):

☐ United Health Care ☐ Amerigroup ☐ Molinia ☐ Other

(If checked) Please provide Information:

Policy Number (#): _____ Group Number: _____

(Please provide a copy of Insurance Card checked above)

Estimated Annual Income of Applicant: _____

Primary source of Income: (Please check)

☐ SSI ☐ Wages ☐ Other

Other means of financial support: _____

FAMILY / CONTACTS

Name of Emergency Contact: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: Home: _____ Other: _____

Mobility (Please check one)

☐ Walks Independently ☐ Walks with assistance from others ☐ Uses wheelchair Independently

☐ Uses wheelchair with assistance from others

Describe / List any adaptive equipment used for mobility:

Describe assistance needed to get from one place to another:

Eats Meal Independently: ◯ Yes ◯ No (No, Please describe help needed:) _____

Bath Independently: ◯ Yes ◯ No (No, Please describe help needed:) _____

Dresses Independently: ◯ Yes ◯ No (No, Please describe help needed:) _____

Rest Room Independently: ◯ Yes ◯ No (No, Please describe help needed:) _____

MEDICAL

Primary Physicians: _____ Tel _____ Fax _____

Address: _____

City: _____ State: _____ ZIP: _____

☐ * I agree that the information provided is, to the best of my ability, accurate and complete.

Applicant Signature: _____ Guardian Signature: _____

Witness Signature: _____ Date: _____