Sunrise
Adult Activity & Health

9525 Wilcrest Drive, Houston, TX 77099

APPLICATION FOR SERVICES

GENERAL INFORMATION

DATE OF APPLICATION: _____

NAME OF APPLCANT: _____
LAST NAME FIRST NAME MIDDLE NAME

PRESENT ADDRESS: STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

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) _____

NAME OF CONTACT, *IF OTHER THAN APPLICANT*

LAST NAME: _____ FIRST NAME: _____

RELATIONSHIP TO APPLICANT: _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

GENERAL PROGRAM INFORMATION

DAYS REQUESTING ATTENDANCE (PLEASE CIRCLE ALL THAT APPLIES) M T W TH F

TIMES REQUESTING ATTENDANCE: START TIME: _____ END TIME:_____

TRANSPORTATION TO AND FROM DAY CARE: (PLEASE CHECK)

_____PERSONAL _____METROLIFT _____PROGRAM TRANSPORT

PARTICIPATING MEALS (PLEASE CIRCLE ALL THAT APPLIES)

B /A.M SNACK/ LUNCH/ P.M SNACK/ DINNER

APPLICATION FOR SERVICES

Name: _____ Date of Birth: _____ Date of Arrival: _____

BACKGROUND INFORMATION

PLACE OF BIRTH: City: _____ County: _____ State: _____

US CITIZENSHIP (PLEASE CHECK) _____ y _____N ETHNICITY: _____ RELIGON: _____

LEGAL STATUS (PLEASE CHECK) _____ COMPETENT _____ INCAPACITATED (COURT APPOINTED GUARD)

If has a Guardian:

Name of Guardian: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Other/ Emergency: _____

Date Appointed by Court: _____ Court Case Number: _____

County: _____ State: _____

INSURANCE INFORMATION

MEDICAID (PLEASE CHECK)

___ Y, NUMBER (#) _____

___ N, HAVE APPLIED AND BEEN DENIED

___ NM HAVE NEVER APPLIED

OTHER SOURCES (PLEASE CHECK)

___ UNITED HEALTHCARE ___ AMERIGROUP ___MOLINIA ___ OTHER

(IF CHECKED) PLEASE PROVIDE INFORMATION

POLICY NUMBER (#) _____ GROUP NUMBER (#) _____

(PLEASE PROVIDE A COPY OF INSURANCE CARD CHECKED ABOVE)

APPLICATION FOR SERVICES

Name: _____ Date of Birth: _____ Date of Arrival: _____

APPLICANT INCOME

ESTIMATED ANNUAL INCOME OF APPLICANT: _____

PRIMARY SOURCE OF INCOME: (PLEASE CHECK) ____**SSI** _____**WAGES** _____ **OTHER** _____

OTHER MEANS OF FINANCIAL SUPPORT _____

FAMILY/ CONTACTS

NAME OF FATHER: _____

DESCRIBE CONTACT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

NAME OF MOTHER: _____

DESCRIBE CONTACT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP TO APPLICANT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

NAME OF EMERGENCY CONTACT: _____

DESCRIBE CONTACT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: HOME: (____) _____-_____ OTHER: (____) _____-_____

APPLICATION FOR SERVICES

Name: _____ Date of Birth: _____ Date of Arrival: _____

MOBILITY/SELF CARE

DESCRIBE APPLICANT'S PARTICIPATION IN COMMUNITY/ NEIGHBORHOOD:

_____
_____
_____
_____

MOBILITY (PLEASE CHECK ONE)

_____ **WALKS INDEPENDENTLY** _____ **WALKS WITH ASSISTANCE FROM OTHERES**

_____ **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: ____Y ____N (NO, PLEASE DESCRIBE HELP NEEDED: _____

BATH MEAL INDEPENDENTLY: ____Y ____N (NO, PLEASE DESCRIBE HELP NEEDED: _____

DRESSES MEAL INDEPENDENTLY: ____Y ____N (NO, PLEASE DESCRIBE HELP NEEDED: _____

REST ROOM INDEPENDENTLY: ____Y ____N (NO, PLEASE DESCRIBE HELP NEEDED: _____

DESCRIBE ANY OTHER ASSISTANCE NEEDED/COMMENTS: _____
_____
_____
_____
_____
_____

APPLICATION FOR SERVICES

Name: _____ Date of Birth: _____ Date of Arrival: _____

INTERACTIONS

DESCRIBE HOW APPLICANT INTERACTS WITH OTHERS: _____

_____

_____

DESCRIBE BEST WAY TO INTERACT WITH OTHERS: _____

_____

_____

DESCRIBE THINGS THAT THE APPLICANT LIKES OR THAT MOTIVATE THAT MOTIVATE HIM/HER:

_____

_____

_____

DESCRIBE APPLICANT'S ABILITY TO MAKE CHOICE: _____

_____

_____

DESCRIBE ANY SIGNIFICANT BEHAVIORS: _____

_____

_____

MEDICAL

PRIMARY PHYSICIAN: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

KNOWN ALLERGIES (FOOD, MEDICATION, OTHER): _____

_____

EXISTING MEDICAL CONDITIONS/DIAGNOSES: _____

_____

I AGREE THAT THE INFORMATION PROVIDED IS, TO THE BEST OF MY ABILITY, ACCURATE AND COMPLETE.

APPLICANT SIGNATURE: _____ **GUARDIAN SIGNATURE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____