

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

Applicant's full name: _____ Birthdate: _____ Sex: _____

Address: _____

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 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 _____

EMERGENCY CARE INFORMATION

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

(1) _____ Name & Relationship to Applicant	_____	E-Mail Address	_____
_____	_____	/	_____
Address/Zip	_____	Home phone	Cell/Work phone-please circle
(2) _____ Name & Relationship to Applicant	_____	E-Mail Address	_____
_____	_____	/	_____
Address/Zip	_____	Home phone	Cell/Work phone-please circle
(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 Saturday
(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 _____
- Duke Energy Corporation _____
- Wachovia Bank _____
- IBM _____
- Microsoft _____
- Philip Morris _____
- UPS _____

REQUIRED

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 Dept. of Aging Scholarship CAP VA Dept. of Social Services
Other: _____

Monthly income: (if applying for assistance) 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 (such as newsletters, calendars, brochures) 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.

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

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: _____

Rural setting: ___ Urban setting: ___ 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 without help or prompting?
(please circle yes or no)

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