



ElderWatch Plus
Adult Day Services

APPLICATION

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Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Social Security Number: _____

Participant Lives with: Spouse Child Independently Other: _____

Participant lives in: Home Apartment Other: _____

Number of steps to enter home: _____ Number of steps inside: _____

Birth Date: _____ Sex: Male Female Race: _____

Hair Color: _____ Eye Color: _____ Veteran _____

Marital Status: Married Widow Divorced Single Spouse's name: _____

Primary Language: _____ Able to: Speak English Read English

Health and Medical:

Medical History +Diagnosis: _____

Recent Hospitalizations /stressful events _____

Allergies: _____ Special Diet: _____

Medications: Prescription and Non Prescription: _____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical Devices used: Glasses Hearing Aid Incontinence pads Walker Cane Wheelchair
O₂ Nebulizer Dentures other _____

Family and community Support:

Responsible Party: _____ Relationship: _____

Address (if different than participant's): _____

City: _____ State: _____ Zip Code: _____ email: _____

Phone : _____ Cell : _____ Work: _____

Power of Attorney: _____ Relationship: _____

Address (if different than participant's): _____

City: _____ State: _____ Zip Code: _____ email: _____

Phone: _____ Cell: _____ Work: _____

Person/Agency responsible for finances: _____

Address (if different than participant's): _____

City: _____ State: _____ Zip Code: _____ email: _____

Phone: _____ Cell: _____ Work: _____

Person/Agency responsible for Medical decisions: _____

Address (if different than participant's): _____

City: _____ State: _____ Zip Code: _____ email: _____

Phone: _____ Cell: _____ Work: _____

Additional support (family and friends):

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

List all health and social service agencies providing services (including PCA):

Agency	Contact person	Phone Number
_____	_____	_____
_____	_____	_____

Physician's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Advanced Directives Living Will Long Term Care Insurance _____

Signature of applicant of responsible party

Date