Main Phone: 704-997-5032
Main Fax: 704-918-1422
Email: Graciousliving@live.com

❒ Gracious Living (Huntersville)
16630 Northcross Drive, Suite A
Huntersville, NC 28078

❒ Gracious Living (South Charlotte)
7950 Nations Ford Road
Charlotte, NC 28217

❒ Gracious Living (Pineville)
10635 Park Rd Medical Office Building
Charlotte, NC 28210

PARTICIPANT'S APPLICATION

Please complete and return. You will be contacted and scheduled an appointment for you to visit Gracious Living ADHCC and for the participant to be evaluated. The participant must have a physical and a TB shot before beginning to receive services through the Adult Day and Health Center. Privately paying participants must pay a $100.00 application fee.

Family and Personal Information

Full Name:	
Address:	
Telephone Number	
Date of Birth:	
Place of Birth:	
Marital Status:	Married Single ○ Divorced ○ Widowed ○
Past employment:	

Name of husband or wife, if living		
With whom does applicant live?		

Participant's Children	Address	Telephone Number	
			Home:

Name and address of next nearest relative or trusted friend who could be contacted in an emergency:			
Name	Address	Telephone Number	

Health History

List any major operations or chronic illnesses or conditions you have experienced.

Name, Address and telephone number of physician(s):

Physician	Address	Telephone

Choice of hospital:
Pharmacy Name:
Telephone:
Medicare:
Part A:
Part B:
Social Security No.:
Other insurance coverage:

Military Service:

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

What assistance (if any) is required in the following areas?

	Area	None	Other	Explain
a.	Walking, Standing	○	○	
b.	Toileting	○	○	
c.	Bathing	○	○	
d.	Eating	○	○	

Dietary Requirements:

a.	Regular diet	☐
b.	Low sodium	☐
c.	Diabetic	☐
d.	Other	☐

Current Medications:	Dosage:	Times Given:

Is supervision required?

○ Yes ○ No Explain:

Starting Date:

Frequency:

Days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Transported by: ☐ Town ☐ Family ☐ Other

Assistance required:

What special needs does the participant have? (i.e., Need for socialization, supervision, etc)

CONTACT IN AN EMERGENCY:

Name:_____

Relationship:_____

Address: _____

Home Phone:_____Work Phone:_____

Cell/Beeper/ Pager No: _____Hours of employment: _____

Physician Name: _____Hospital Affiliation : _____

Phone: Extension: _____

ALTERNATE CONTACT

Name: Relationship:

Address: _____ _____

Home Phone: _____Work Phone: _____

Cell/ Beeper / Pager No.: _____

Signature of Applicant / Caregiver/ P.OA: _____

Date:_____