Seniors' Resource Center Adult Day and Respite Services
Emergency Information

PARTICIPANT INFORMATION	
Participant Name:	**DNR or CPR Directive ☐ Yes ☐ No** **If yes, please provide a copy to program.**
Today's Date:	**Participant's Birth Date:**
Sex: ☐ M ☐ F ☐ T	**E-Mail:**
Address:	
City:	**State:** **Zip Code:**
Home Phone # :	**Medicare # :**
Living Arrangement With:	**Social Security # :**
Known Allergies:	**Medicaid # :**

RESPONSIBLE PARTY or PRIMARY CONTACT	
Is participant to be considered the responsibility party? c Yes c No	
Name:	
Relationship to Participant:	
Address:	
City:	**State:** **Zip Code:**
Home Phone # :	**Work Phone # :**
Cell Phone # :	**Employer Name:**
Billing: ☐ Yes ☐ No Newsletter: ☐ Yes ☐ No	**E-Mail:**

SECONDARY CONTACT	
Name:	
Relationship to Participant:	
Address:	
City	**State:** **Zip Code:**
Home Phone # :	**Work Phone # :**
Cell Phone # :	**Employer Name:**
Billing: ☐ Yes ☐ No Newsletter: ☐ Yes ☐ No	**E-Mail:**

EMERGENCY	
Hospital Preference:	**Insurance:**

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PLEASE TURN PAGE OVER

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PRIMARY PHYSICIAN INFORMATION	
Physician Name (First & Last):	
Clinic:	
Address:	
City:	**State:** **Zip Code:**
Phone # :	**Fax # :**

SECONDARY PHYSICIAN INFORMATION	
Physician Name (First & Last):	
Clinic:	
Address:	
City:	**State:** **Zip Code:**
Phone # :	**Fax # :**

CASE MANAGER INFORMATION	GUARDIAN/ADVOCATE INFORMATION
Name:	**Name:**
Agency:	**Address:**
Address:	**Phone #:**
Phone #:	**Fax # :**
Fax #:	

ADVANCE DIRECTIVES	
Do you have a living will? ☐ Yes ☐ No	Are you an organ donor? ☐ Yes ☐ No

FINANCIAL POWER OF ATTORNEY	MEDICAL POWER OF ATTORNEY
Name:	Do you have a Medical Power of Attorney ☐Yes ☐No
Relationship:	Name:
Phone:	Relationship:
Address:	Phone:
	Address:
Please note here if Medical POA is the same ☐ ?	

PLEASE SIGN HERE TO INDICATE THAT THIS INFORMATION IS CORRECT	
Signature:	**Date:**

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DEMOGRAPHIC DATA	
County of Residence: ☐ Jefferson ☐ Clear Creek ☐ Gilpin ☐ Arapahoe ☐ Adams ☐ Park ☐ Denver ☐ Broomfield ☐ Other:	
Lifestyle Status: ☐ Married ☐ Widowed ☐ Separated ☐ Partner ☐ Never Married ☐ Divorced	
Ethnicity: ☐ Caucasian ☐ Latino ☐ Black ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander	
☐ Native American ☐ Alaskan Native ☐ Other	
Primary Language:	Fluency: ☐ High ☐ Medium ☐ Low
Secondary Language:	Fluency: ☐ High ☐ Medium ☐ Low
Poverty level as established by the Department of Health & Human Services ☐ Above ☐ Below ☐ Not Sure	

OTHER SERVICES CURRENTLY USED (PROVIDED BY THIS AGENCY OR OTHERS)
In Home Care ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech ☐ Friendly Visitor ☐ Meals on Wheels ☐ Transportation ☐ Care Management ☐ Other

ADDITIONAL CONTACTS	
Name:	
Relationship to Participant:	
Address:	
City:	State: Zip Code:
Home Phone # :	Work Phone # :
Cell Phone # :	Employer Name:
Billing: ☐ Yes ☐ No Newsletter: ☐ Yes ☐ No	E-Mail:
Name:	
Relationship to Participant:	
Address:	
City:	State: Zip Code:
Home Phone # :	Work Phone # :
Cell Phone # :	Employer Name:
Billing: ☐ Yes ☐ No Newsletter: ☐ Yes ☐ No	E-Mail:

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