

**Seniors' Resource Center Adult Day and Respite Services
Emergency Information**

PARTICIPANT INFORMATION	
Participant Name:	DNR or CPR Directive <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a copy to program.
Today's Date:	Participant's Birth Date:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Newsletter: <input type="checkbox"/> Yes <input type="checkbox"/> No	E-Mail:
SECONDARY CONTACT	
Name:	
Relationship to Participant:	
Address:	
City	State: Zip Code:
Home Phone # :	Work Phone # :
Cell Phone # :	Employer Name:
Billing: <input type="checkbox"/> Yes <input type="checkbox"/> No Newsletter: <input type="checkbox"/> Yes <input type="checkbox"/> No	E-Mail:
EMERGENCY	
Hospital Preference:	Insurance:
PLEASE TURN PAGE OVER	

1/28/2014

**Seniors' Resource Center Adult Day and Respite Services
Emergency Information**

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you an organ donor? <input type="checkbox"/> Yes <input type="checkbox"/> No
FINANCIAL POWER OF ATTORNEY	MEDICAL POWER OF ATTORNEY
Name:	Do you have a Medical Power of Attorney <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship:	Name:
Phone:	Relationship:
Address:	Phone:
	Address:
Please note here if Medical POA is the same <input type="checkbox"/> ?	
PLEASE SIGN HERE TO INDICATE THAT THIS INFORMATION IS CORRECT	
Signature:	Date:
1/28/2014	
NEXT PAGE PLEASE	

**Seniors' Resource Center Adult Day and Respite Services
Emergency Information**

DEMOGRAPHIC DATA	
County of Residence: <input type="checkbox"/> Jefferson <input type="checkbox"/> Clear Creek <input type="checkbox"/> Gilpin <input type="checkbox"/> Arapahoe <input type="checkbox"/> Adams <input type="checkbox"/> Park <input type="checkbox"/> Denver <input type="checkbox"/> Broomfield <input type="checkbox"/> Other:	
Lifestyle Status: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced	
Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> Latino <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Other	
Primary Language:	Fluency: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
Secondary Language:	Fluency: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
Poverty level as established by the Department of Health & Human Services <input type="checkbox"/> Above <input type="checkbox"/> Below <input type="checkbox"/> Not Sure	
OTHER SERVICES CURRENTLY USED (PROVIDED BY THIS AGENCY OR OTHERS)	
In Home Care <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech <input type="checkbox"/> Friendly Visitor <input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Transportation <input type="checkbox"/> Care Management <input type="checkbox"/> Other	
ADDITIONAL CONTACTS	
Name:	
Relationship to Participant:	
Address:	
City:	State: Zip Code:
Home Phone # :	Work Phone # :
Cell Phone # :	Employer Name:
Billing: <input type="checkbox"/> Yes <input type="checkbox"/> No Newsletter: <input type="checkbox"/> Yes <input type="checkbox"/> No	E-Mail:
Name:	
Relationship to Participant:	
Address:	
City:	State: Zip Code:
Home Phone # :	Work Phone # :
Cell Phone # :	Employer Name:
Billing: <input type="checkbox"/> Yes <input type="checkbox"/> No Newsletter: <input type="checkbox"/> Yes <input type="checkbox"/> No	E-Mail:

1/28/2014