7121 Old Alexandria Ferry Road
Clinton, MD 20735
Phone: (301) 856-5553
Fax: (301) 856-5512

5400 Norfield Road
Capitol Heights, MD 20743
Phone: (301) 736-6622
Fax: (301) 856-5512

APPLICATION FOR ENROLLMENT

Applicant's Name: _____

Address: _____
(#, Street) (Apt #) (City) (State) (Zip)

Telephone #: ( ) _____ Social Security #: _____

Date of Birth: _____ / _____ / _____ Sex: Male _____ Female _____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____

Referred to Helping Hands by: _____

Known behavioral problems: _____

Applicant's current living situation: Alone _____ With Spouse _____
Other family member _____ Relationship _____
Group Home _____ Name _____
Assisted Living Community _____ Name _____
Nursing Home _____ Name _____
Other (Specify) _____

Name of primary caregiver: _____

Is applicant own guardian? Yes _____ No _____ If no, please provide the following information:

Name of guardian: _____
(if different from primary caregiver listed above)

Address: _____

Telephone #s: _____

Sources of Payment

Medical Assistance # _____
VA _____
Insurance Company _____
Community Funding _____
Other _____

Primary Physician

Name: _____

Telephone #s: _____

Mailing Address: _____

Other Medical Specialist or Service Provider

Name: _____

Telephone #s: _____

Please provide information about the applicant's last hospitalization

Date: _____

Reason: _____

Hospital: _____

Additional comments or information: _____

_____

_____

_____

Applicant needs assistance

Bathing _____ Eating _____ Toileting _____ Getting dressed _____ Climbing stairs _____
Walking _____ Sitting in & getting out of chairs _____ Getting in and out of bed _____
Taking medication _____

Applicant's Continence Management

Complete control _____ Incontinent of bladder _____ Incontinent of bowel _____

Device(s) used:

Wheelchair _____ Crutches _____ Walker _____ Cane _____ Braces _____ Prosthesis _____

Applicant's health condition and concerns (a complete history and physical exam is required by your physician to include TB screening – PPD or Chest x-ray):

_____ Controlled _____ Under Dr. Care _____

_____ Controlled _____ Under Dr. Care _____

_____ Controlled _____ Under Dr. Care _____

_____ Controlled _____ Under Dr. Care _____

Allergies (drugs, food, and others): _____

_____

Medications

Type: _____ Dosage: _____

Type: _____ Dosage: _____

Type: _____ Dosage: _____

Type: _____ Dosage: _____

In the event of an emergency contact: _____

IF THIS PERSON IS NOT LISTED AS CAREGIVER OR GUARDIAN, PLEASE INDICATE:

Relationship to applicant: _____

Address: _____

Telephone #s: _____

Second emergency contact: _____

Relationship to applicant: _____

Address: _____

Telephone #s: _____

Please provide the name of the power of attorney, or next of kin for medical decisions to contact in case of medical emergency.

Name: _____

IF THIS PERSON IS NOT LISTED ANYWHERE ON THIS APPLICATION, PLEASE INDICATE:

Address: _____

Telephone #s: _____

Please provide the name of the person responsible for payments:

Name: _____

Address: _____

Telephone #s: _____

Relationship to applicant: _____

Guarantor's Signature: _____

Applicant's Diet and Nutrition Information

Appetite: Good _____ Fair _____ Poor _____

Diet Restrictions: _____

Food and Beverage Favorites: _____

Food and Beverage Dislikes: _____

Applicant's Religious Interests

Religious Preference Yes _____ No _____ If yes, please specify _____

Church Affiliation Yes _____ No _____ If yes, church name _____

Applicant's Hobbies

_____

_____

_____

All information provided on this application is complete and accurate.

_____ _____

Date Signature of Applicant or Representative