ALPS Adult Day Services

Participant Registration Form

name: _____ phone: _____

street: _____ city: _____ state: _____ zip: _____

date of birth: _____ age: _____ Social Security number: _____ marital status: _____

religion: _____ date enrolled: _____

primary caregiver's name: _____ relationship: _____

street: _____ city: _____ state: _____ zip: _____

occupation: _____ employer: _____ work phone: _____

home phone: _____ cell phone: _____ other: _____

e-mail address: _____

person responsible for payment: _____

address (if different from above): _____

Please list at least two people we could contact in the event of an emergency if the caregiver cannot be reached. These phone numbers must be current; please let us know if any changes occur.

name: _____ relationship: _____ phone: _____

Additional number(s) for this contact: _____

name: _____ relationship: _____ phone: _____

Additional number(s) for this contact: _____

participant's primary physician: _____ phone: _____

other physician(s): _____

preferred Morristown hospital (please circle*):* *Lakeway Regional Hospital* or *Morristown-Hamblen Healthcare System*

names of persons who are authorized to pick up participant from ALPS:

_____

_____

Please read the following statement, then sign and date below.

In the event of an emergency, I give permission for _____ to be transported to the nearest emergency room or to my preferred hospital (depending upon the nature of the emergency). I understand that I am responsible for all charges resulting from the emergency care, including ambulance or rescue squad charges. I also give permission for ALPS staff to provide emergency medical personnel with any information which will assist them in treatment of the emergency.

caregiver's signature: _____ date: _____

caregiver's name (printed): _____

***Please provide ALPS with copies of the participant's Social Security card, insurance card(s), and Medicare card which we will keep on file in the event of an emergency.**