LIVE WELL AT IWILEI
ADMISSION APPLICATION

APPLICATION DATE: _____

NAME:

_____

LAST FIRST MIDDLE

MAILING ADDRESS:

_____

Street City State Zip code

PRIMARY LANGUAGE: _____ RACIAL EXTRACTION: _____

PHONE NUMBER: _____ MARITAL STATUS: _____

EMAIL ADDRESS: _____ RELIGION: _____

DATE OF BIRTH: _____AGE:_____SEX:_____

HOW DID YOU HEAR ABOUT US?:_____

IN CASE OF EMERGENCY. NOTIFY:

FIRST POINT OF CONTACT:

NAME: _____PHONE: _____

ADDRESS: _____

Street City State Zip Code

RELATIONSHIP: _____ EMAIL: _____

SECOND POINT OF CONTACT:

NAME: _____PHONE NUMBER: _____

ADDRESS: _____

Street City State Zip Code

RELATIONSHIP: _____ EMAIL: _____

INDIVIDUAL RESPONSIBLE FOR PAYMENT:

NAME: _____ PHONE NUMBER: _____

ADDRESS: _____
Street City State Zip Code

RELATIONSHIP: _____ EMAIL: _____

SIGNATURE: _____

DAY SERVICES REQUESTED: **MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY**
(Circle all that apply)

SPECIFIC HOURS REQUESTED: _____

EARLY DROP OFF REQUEST: **MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY**
(Circle all that apply)

SHOWER REQUESTED: **MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY**
(Circle all that apply) –Complete Shower Consent)

OTHER INFORMATION YOU WOULD LIKE TO SHARE (including additional contacts):

PHYSICIAN'S NAME: _____ PHONE NUMBER: _____

FAX NUMBER: _____

ADDRESS: _____
Street City State Zip Code

HOSPITAL PREFERENCE FOR EMERGENCIES: _____

ALTERNATIVE PHYSICIAN IF PCP CANNOT BE REACHED: _____

PHONE NUMBER _____

MEMBER SIGNATURE AUTHORIZING THE CENTER TO CONTACT THE MEMBER'S LISTED EMERGENCY CONTACTS, PHYSICIAN OR ALTERNATIVE PHYSICIAN (IF PCP NOT AVAILABLE):

_____ _____
MEMBER'S SIGNATURE DATE

_____ _____
FAMILY/RESPONSIBLE PARTY SIGNATURE DATE

FOR OFFICIAL USE ONLY

INTERVIEW/EVALUATION DATE: _____
CONDUCTED BY: _____
PHYSICAL EXAMINATION COMPLETED: _____ (YES/NO & DATE COMPLETED)
TB CLEARANCE RECEIVED: _____
_____
OTHER INFORMATION REQUESTED OR REQUIRED (examples: Lifetime occupation, hobbies, interests, behavior, wandering, etc.)

START DATE: _____

REASON DENIED:
_____
_____
_____
_____

APPLICATION APPROVED BY:

_____ DATE: _____

REVIEW OF CENTER POLICIES COMPLETED BY:

_____ DATE: _____

FEE SCHEDULE PROVIDED BY:

_____ DATE: _____

ADDITIONAL COMMENTS:

Copy of Photo Identification of Member Received _____

Copy of Completed Physical Examination Received _____