SCOTLAND HOUSE
Adult Day Health & Wellness

(802) 280-3064

PARTICIPANT DEMOGRAPHICS/CARE CONSIDERATIONS

NAME: _____ **AGE**: _____ **PHONE**: _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS:_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Other _____ **VETERAN: Yes/No** ☐ ☐

LIVING ARRANGEMENTS: ☐ Independent ☐ Caregiver ☐ Family ☐ Spouse

MOBILITY: ☐ Walker ☐ Wheelchair ☐ Cane

DIETARY REQUIREMENTS: _____

Special considerations or information you would like us to know:

_____

_____

PRIMARY CARE PROVIDER (NAME/LOCATION): _____

PREFERRED HOSPITAL IN CASE OF EMERGENCY: _____

RESPONSIBLE PARTY/EMERGENCY CONTACT INFORMATION

NAME: _____ **RELATIONSHIP**: _____

STREET ADDRESS: _____ **CITY/STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK:** _____ **CELL:** _____

EMAIL: _____

SCOTLAND HOUSE SCHEDULING INFORMATION

Check Days: ☐ ☐ ☐ ☐ ☐ ☐

DESIRED START DATE: _____ **DESIRED DAYS OF WEEK: M T W Th F ALL**

PAYMENT: ☐ Private Pay ☐ VA ☐ VT/NH/MA Medicaid ☐ Grant

TRANSPORTATION: ☐ Family ☐ Scotland House ☐ Caregiver