Quality Daytime Care
ADULT CARE CENTER
OF ROANOKE VALLEY
2321 Roanoke Blvd.
Salem, VA 24153
Phone 540-981-2350 Fax 540-981-2353

Application for Enrollment

Applicant's Name: _____

Address: _____ State: ___ Zip: _____ County: _____

Telephone: _____ Date of Birth: ___/___/___ Age: _____

S.S. # _____-_____-_____ Education: _____ Previous Occupation: _____

Marital Status: S_____ M_____ W_____ D_____ Veteran: Y_____ N_____

Present Living Situation: _____

Primary Caregiver: _____ Relationship: _____

Address: _____ Phone: _____ Email: _____

1st Emergency Contact: _____ Phone (cell/home): _____ Work: _____

Address: _____

2nd Emergency Contact: _____ Phone (cell/home):: _____ Work: _____

Address: _____

Power of Attorney or Legal Guardian: _____

Resides in: Roanoke City_____ Roanoke County_____ Salem_____ Vinton_____ Other_____

Primary Care Physician: _____ Telephone: _____

Primary Care Physician address: _____. Fax: _____

Address: _____

Hospital Preference: _____ Date of Last Hospitalization: _____

Desired Days of Attendance: **Monday**____ **Tuesday**____ **Wednesday**____ **Thursday**____ **Friday**____

Please give a brief description of need for program:

_____

_____

Form of payment for program: VA benefits: ____; Private pay: ____;
Medicaid: _____; Long term care insurance _____.