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

Enrollee's Name: _____

Address: _____ State: _____Zip: _____

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

Email Address: _____ S.S. # _____-_____-_____ Education: _____

Previous Occupation: _____

Marital Status: S_____ M_____ W_____ D_____ Veteran: Y_____ N_____

Present Living Situation: _____

Primary Caregiver: _____Relationship: _____

Address: _____Telephone:_____

1st
Emergency Contact: _____Home phone: _____Work: _____

Address: _____

2 nd
Emergency Contact: _____Home phone: _____Work: _____

Address: _____

Power of Attorney or Legal Guardian: _____

Resides in: Roanoke City_____ Roanoke County_____ Salem_____ Vinton_____ Other_____

Primary Care Physician: _____ Telephone: _____

Address: _____

Hospital Preference: _____Date of Last Hospitalization: _____

Desired Days of Attendance (Two Minimum) Mon_____ Tues_____ Wed_____ Thurs____ Friday_____

Please give a brief description of need for program:

_____

_____

Form of program payment – Circle One: VA Benefits Private Pay Medicaid Long Term Care Insurance

Further help with financial assistance is needed