Michigan Integrated Day & Health Services, LLC

3249 Hilton Rd.
Ferndale, MI 48220
248.307.7431
admin@michiganintegratedrehab.com

- Fill out all requested information by printing or typing (except signatures).
- Attach pages if needed for additional information.
- Once complete, mail, fax, or scan and email application to the center.

After receiving the application, the center will call and set up an appointment for a visit and for the applicant to be evaluated.

Admission Application

Applicant Name _____
(Last) (First) (Middle)

Address _____
(Street/Apt.) (City) (State) (Zip)

Phone _____ Social Security # ____ - ___ - ____ Religion _____

Sex (circle) M F Age ____ Date of Birth ___ /___ /_____ Place of Birth (city/state) _____
(MM) (DD) (YYYY)

Marital Status (circle) Married Single Divorced Widowed Name of spouse (if living): _____

With whom does applicant live? _____ Relationship_____

Alternate emergency contact _____ Phone _____

Address _____
(Street/Apt.) (City) (State) (Zip)

Applicant Health History

List any major operations, chronic illnesses, and medical conditions _____

_____

_____

_____

Personal Physician _____ Phone _____

Address _____
(Street/Apt.) (City) (State) (Zip)

Preferred hospital _____

Pharmacy _____ Phone _____

Medicare/Insurance Information

- ☐ Part A Claim # _____
- ☐ Part B Claim #
- ☐ Other insurance coverage _____

Admission p. 2 Name _____

What assistance is required in the following areas?

- ☐ Walking, Standing Explain _____
- ☐ Toileting Explain _____
- ☐ Bathing Explain _____
- ☐ Eating Explain _____

Dietary Requirements

- ☐ Regular diet
- ☐ Low sodium
- ☐ Diabetic
- ☐ Other Explain _____

Current Medications	Dosage	Times Given

Is supervision or help required with medications? Yes No (circle) Explain (If yes) _____

Requested starting date _____ Days: (circle) Monday Tuesday Wednesday Thursday Friday

Transported by City Family (circle) Other _____

Transportation assistance required _____

What additional special needs does the applicant have? (i.e., need for socialization, supervision, etc.) _____

_____

Name and address of person or agency responsible for payment of adult day services: _____

_____

Name of person completing this form: _____

_____