INDIVIDUAL ENROLLMENT

Facility Name: ______________________________

Address: ______________________________

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Participant Name: ______________________________

Address: ______________________________

City,State, Zip: ______________________________

Home Phone: ______________________________

Living Arrangements: ______________________________
(indicate name and relationship)

Legal Status: ______________________________
competent or incompetent

Diagnosis: ______________________________

Assessments/Goals: **Yes ____ No____**

Medical statement on file for food allergies:
Yes ____ No____

Date of Birth:________________ **Care Plan Start Date:**_______________

Food Stamp # ______________

Medicaid#: ________________ **Care Plan End Date:**_______________

Supplemental Security Income #:________ _________ ________________

Medical Exam Date:___________

Hours in Care:_____**AM** _____**PM**

Days in Care: Circle all that apply)

Monday Tuesday Wednesday Thursday Friday

Meals in Care: Circle all that apply)

Breakfast AM Snack Lunch PM Snack Supper

Description of allergy: (list allergy and if none, list none)________

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*****Attach Income Eligibility Statement.**