MENTOR SENIOR CENTER
SPECIAL ELDERS PROGRAM APPLICATION

NAME_____ DATE OF BIRTH _____

ADDRESS_____ CITY/ZIP_____

HOME PHONE_____ CELL PHONE_____

MEDICAL CHALLENGES _____

PHYSICAL CHALLENGES _____

MENTAL CHALLENGES _____

"I NEED HELP WITH_____

BECAUSE _____."

CURRENT MEDICATIONS_____
(OK to attach separate sheet)

ALLERGIES (foods, medications, bee stings, etc.) _____

OTHER INFORMATION USEFUL TO US _____

PHYSICIAN NAME_____ **PHONE**_____

HOSPITAL PREFERENCE (in case of an emergency) _____

#1 EMERGENCY CONTACT NAME_____ PHONE _____

RELATIONSHIP TO YOU _____ PHONE _____

#2 EMERGENCY CONTACT NAME_____ PHONE _____

RELATIONSHIP TO YOU _____ PHONE _____

INTERESTS THAT BRING YOU TO THE SENIOR CENTER_____

STOP HERE ********** ***STOP HERE***

☐ *PROGRAM CRITERIA HAS BEEN REVIEWED WITH ME* _____
(signature)

☐ *I UNDERSTAND THE PROGRAM CRITERIA FOR ELIGIBILITY*_____
(signature)

☐ *I UNDERSTAND THAT MY ELIGIBILITY WILL BE PERIODICALLY ASSESSED FOR CONTINUATION/RENEWAL* _____
(signature)

DATE_____ **ENROLL/RENEW/TEMP** STAFF _____
(circle one) (signature)