Shirley's Adult Day Center/Chair Lift Application

Name: _____
(last) (first) (mi)
Address: _____ **City State Zip**: _____
Phone: _____**Email**: _____ **Primary Language:** _____
DOB: _____ **Age:**_____ **Sex:**_____
Medical Notes: Check all that apply.
DNR: ☐ **Diabetic:** ☐ **Seizures:** ☐ **Allergies:** _____

IN CASE OF EMERGENCY NOTIFY:
Primary:
Name: _____ Relationship: _____
Address: _____
Phone: Cell: _____ Home: _____ Work: _____

IN CASE OF EMERGENCY NOTIFY:
Secondary:
Name: _____ Relationship: _____
Address: _____
Phone: Cell: _____ Home: _____ Work: _____

Applicant or Guardian Signature: _____
Date: _____

Transportation Manager Signature: _____
Date: _____

**We provide services based on suggested rate. The rate is based on cost of operation. Please pay what you can of this amount, to help us to continue to provide transportation services.

For your request for transportation, the amount is
_____# miles x.54 ==_____

_____hours at $15.00 per half hour==_____

_____ TOTAL

Payment is expected at time of service unless other arrangements have been made. Out of city limits and special needs will be based at a possible different rate; call for explanation.

Thanks for your support.

Shirley's Adult Day Center.