

*ALPS Adult Day Services*  
**Participant Registration Form**

name: \_\_\_\_\_ phone: \_\_\_\_\_

street: \_\_\_\_\_ city: \_\_\_\_\_ state: \_\_\_\_\_ zip: \_\_\_\_\_

date of birth: \_\_\_\_\_ age: \_\_\_\_\_ Social Security number: \_\_\_\_\_ marital status: \_\_\_\_\_

religion: \_\_\_\_\_ date enrolled: \_\_\_\_\_

primary caregiver's name: \_\_\_\_\_ relationship: \_\_\_\_\_

street: \_\_\_\_\_ city: \_\_\_\_\_ state: \_\_\_\_\_ zip: \_\_\_\_\_

occupation: \_\_\_\_\_ employer: \_\_\_\_\_ work phone: \_\_\_\_\_

home phone: \_\_\_\_\_ cell phone: \_\_\_\_\_ other: \_\_\_\_\_

e-mail address: \_\_\_\_\_

person responsible for payment: \_\_\_\_\_

address (if different from above): \_\_\_\_\_

*Please list at least two people we could contact in the event of an emergency if the caregiver cannot be reached. These phone numbers must be current; please let us know if any changes occur.*

name: \_\_\_\_\_ relationship: \_\_\_\_\_ phone: \_\_\_\_\_

Additional number(s) for this contact: \_\_\_\_\_

name: \_\_\_\_\_ relationship: \_\_\_\_\_ phone: \_\_\_\_\_

Additional number(s) for this contact: \_\_\_\_\_

participant's primary physician: \_\_\_\_\_ phone: \_\_\_\_\_

other physician(s): \_\_\_\_\_

preferred Morristown hospital (please circle): *Lakeway Regional Hospital* or *Morristown-Hamblen Healthcare System*

names of persons who are authorized to pick up participant from ALPS:

\_\_\_\_\_

\_\_\_\_\_

**Please read the following statement, then sign and date below.**

*In the event of an emergency, I give permission for \_\_\_\_\_ to be transported to the nearest emergency room or to my preferred hospital (depending upon the nature of the emergency). I understand that I am responsible for all charges resulting from the emergency care, including ambulance or rescue squad charges. I also give permission for ALPS staff to provide emergency medical personnel with any information which will assist them in treatment of the emergency.*

**caregiver's signature:** \_\_\_\_\_ **date:** \_\_\_\_\_

**caregiver's name (printed):** \_\_\_\_\_

**\*Please provide ALPS with copies of the participant's Social Security card, insurance card(s), and Medicare card which we will keep on file in the event of an emergency.**