ASSISTED SENIOR PROGRAM Application

Date: _____

Please print, sign and complete the entire application form. All participant information provided is strictly confidential.

***ASP Member's Name**

Courtesy Title (Please mark one): Mr ___ Mrs ___ Miss ___ Ms ___ Dr ___ Rev ___ Hon ___ Other _____

Last Name	First Name	Middle Name	Suffix	Name go by

***Client's Physical Address**

Street	City	State	Zip	*County

Phone	Email	*Municipality (i.e. Borough, Township, City)

Financial responsibility for ASP Program

Courtesy Title (Please mark one): Mr ___ Mrs ___ Miss ___ Ms ___ Dr ___ Rev ___ Hon ___ Other _____

Last Name	First Name	Middle Name	Suffix	Name go by

Relationship to Member: _____

***Financial Responsible Person Mailing Address (only if different from Client's address)**

Street	City	State	Zip	*County

Phone	Email	*Municipality (i.e. Borough, Township, City)

Caregiver's Name for ASP Member: **Same as person above?** Yes ___ No ___

If not the same person listed as Financially responsible, please fill in information below:

Courtesy Title (Please mark one): Mr ___ Mrs ___ Miss ___ Ms ___ Dr ___ Rev ___ Hon ___ Other _____

Last Name	First Name	Middle Name	Suffix	Name go by

Relationship to Member: _____

***Caregiver's Mailing Address (only if different from Client's address)**

Street	City	State	Zip	*County

Phone	Email	*Municipality (i.e. Borough, Township, City)

Power of Attorney (Please Print): _____

Phone: _____ Relationship: _____

I, _____ give permission for _____

To be taken to a hospital in the event of an emergency. Every effort will be made to contact me at the phone numbers which I have provided under "Emergency Contact" on side 2.

How did you learn about us?: KASC Member ___ Friend/Relative ___ Facebook ___

Other Organization, please specify _____ Other _____

***** More on other side, Signature Required, please turn over, complete, read and sign on other side *****

Mission

The Kennett Area Senior Center is committed to preserving and enhancing the dignity and well-being of all adult residents of southern Chester County by providing a vital assortment of services that enrich social relationships, foster physical health,

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Last Name	First Name	Middle Name	Suffix	Name go by

Emergency Contact Information (Please provide two emergency contacts.)

Name of contact: _____ Name of contact: _____

Relationship: _____ Relationship: _____

Work Phone: _____ Work Phone: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Email Address: _____ Email Address: _____

Medical Information

Primary Care Physician _____ Phone _____

Hospital of choice in case of an emergency:

*Please note acute emergency will be automatically transported to Chester County Hospital

Chester County ____ Jennersville Regional ____ Christiana ____ Riddle ____ No Preference ____

Health Conditions: _____

Allergies: _____

Limitations: _____

Special Concerns: Diabetes, Seizures, Urinary or Bowel Problems: _____

Over the counter medications and dosages: _____

Vitamins, Mineral, Herbal Supplements and dosages: _____

Medical Prescriptions and dosages: _____

Member's Special Interests, Hobbies, Talents, etc. Please include both past and present.

***Signature*:** _____ **Date:** _____

For office use only: KASC ID# _____

ASP Entrance Fee - $50 (Payable one time only) ____ Date Paid: _____ Check _____

ASP Fee: $10.00 per Hour Cash _____ Check # _____

Interview Date: _____ Program Start Date: _____