GRACE ADULT DAY HEALTH CARE

Dear Applicant,

Thanks for your interest in Grace Adult Day Health care; we look forward to partnering with you and your family in your life journey.

Enclosed, please find the application package you requested. If you have any questions, contact our social work department for assistance at (408) 727-6280. The Grace Intake coordinator will contact you upon receiving your application.

Here is what you need to apply:

If you already belong to a Managed Health Plan, please visit your healthcare provider to complete the Grace Physician Health Assessment form along with TB clearance. The completed package can be faxed, mailed, or hand-delivered.

If you don't yet belong to a Managed Health Plan, please contact: 1-844-580-7272

- Santa Clara County residents can choose between Anthem Blue Cross and Santa Clara Family Health Plan.
- Alameda County residents can choose between Anthem Blue Cross and Alameda Alliance.
- For Farsi, please call1-800-840-5034
- For Mandarin, please call1-800-576-6885
- For Vietnamese, please call: 1-800-430-8008
- For Spanish, please call: 1800-430-3003

Who is Eligible?

Individuals may be eligible:

- If they have a medical condition that requires treatment or rehabilitative services prescribed by a physician and;
- A physical and/or mental impairment that handicaps activities of daily living but is not so severe as to require 24-hour institutional care and;
- A reasonable expectation that preventative services will maintain or improve the present level of functioning and;
- There is a high chance of further deterioration and possible institutionalization if ADHC services are unavailable.

What is The Program Cost?

Medi-Cal, Managed Health Plan, VA, or LTC Insurance may cover the entire program cost for eligible persons.

For Private Pay clients without Medi-Cal insurance, you only need to complete the application along with the TB test. To get more information and cost for Private Pay clients, please call the center at (408) 731-8686.

Meals and Transportation

Nutritious breakfast, hot lunch and snacks are provided every day. Safe, reliable, door-to-door transportation is also provided in most areas of Santa Clara County, as well as city of Fremont.

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Applicant Information

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____Zip code: _____

Home Phone: _____ Mobile _____ Email: _____

Medi-Cal Number: _____ Issue Date: _____
Medicare Number: _____
SSN: _____

Managed Care Organization:
☐ Anthem ☐ Alliance ☐ SCFHP ☐ HPSM

Health Information:
Last Hospitalization: _____
Reason_____
Last ER visit: _____ Reason_____

History of Aggression: __Y __ N
History of Wandering: __Y __ N
Last Fall: _____
Assistive Device: ___Walker ___Cane ___Wheelchair

Type of Residents: ☐ House ☐ Apartment ☐ Residential Care Facility ☐ ICF/DD-H

Living Arrangement: ☐ Alone ☐ Relative (specify) _____ ☐ Other (specify) _____

Ambulation:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Bathing:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Dressing:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Self-Feeding:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Toileting:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Transferring:
☐ Independent ☐Needs Assistance ☐Needs Supervision

Accessing Resources:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Hygiene:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Meal Preparation:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Medication Management:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Money Management:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Daytime Medication Administration:
☐ Independent ☐Needs Assistance ☐Needs Supervision
Transportation to Medical Appointments:
☐ Independent ☐Needs Assistance ☐Needs Supervision

Emergency Contact:
Last Name: _____ First Name: _____
Relationship: _____
Address: _____
Home Phone: _____ Mobile _____
Email: _____

Secondary Contact
Last Name: _____ First Name: _____
Relationship: _____
Address: _____
Home Phone: _____ Mobile _____
Email: _____

Please list ALL active treating physicians

Care Provider	Name	Address	Phone	Fax
Primary Care				
Cardiologist				
Psychiatrist				
Other:				

Referred By: _____ Reason for CBAS services: _____

Completed by: _____Date: _____