SUNFLOWER

Surveyor: Date:

Membership Eligibility Survey

First Name: **Last name :** **DOB:**

Address:

Phone: **Email:**

Medicaid#: **HMO Name:** **HMO ID #**

Caregiver name: **Caregiver phone:**

Relationship to member: **Caregiver Email:**

Doctor: **Doctor Phone:**

DX(Current Medical Issues):

Currently Uses(Circle One): **Cane** **Wheelchair** **Walker** **None**

Allergies:

Pharmacy Name: **Pharmacy #:**

I (Member Name) _____ grant permission to (Print Surveyor Name)Center, to be considered for membership. I understand that the information provided on this form with Sunflower Adult Medical Adult Day Center, and WILL NOT be shared with any parties.

Member's Signature_____ Date:_____

Surveyor's Signature_____ Date:_____

Office Use Only

Processed By:_____ Date:_____

Approved (Yes or No): **Reason:**

Notes: **We Accept Medicaid, Private Pay, and Respite (Not Medicare)**