



Membership Number _____

Capital City Senior Programs
1085 Chalkstone Avenue
Providence, RI 02908

Membership Enrollment Application

Date: _____

Intake Worker: _____

Name	_____	Telephone #	_____
Address	_____ _____ _____		
Date of Birth	____/____/____	Sex: Male	____ Female ____
Social Security #	____/____/____		

Marital Status: Married ____ Windowed ____ Separated ____

Divorced ____ Single ____

Race: White ____ Black ____ Asian ____

Hispanic ____ Other ____

Household Composition – Lives:

Alone ____ With Spouse ____ With Child ____

With Relative ____ With Non/Relative ____

Living Arrangements:

Own Home ____ Rent ____ Private Senior Housing ____

Public Senior Housing ____ Assisted Living ____ Nursing Home ____

Primary Language: _____ Translator Required: Yes ____ No ____

Monthly Income Range:

_____ \$0 to \$581	_____ \$582 to \$786	_____ \$787 to \$991
_____ \$992 to \$1,196	_____ \$1,197 to \$1,401	_____ \$1,402 to \$1,606
_____ \$1,607 to \$1,811	_____ \$1,812 +	



Medical Information

In Case of Emergency

Name _____

Phone # _____

Relationship _____

Daytime #, if different _____

Member's Name: _____

Medical History

Please indicate any illness or injuries for which you are receiving medical treatment.

Please indicate any medication(s) (and its purpose) that you are now taking.

Please indicate any food and/or medication allergies.

Name of Primary Physician: _____

Phone #: _____

Hospital Preference: _____



Medical Authorization

In consideration of acceptance of membership to Lillian Feinstein Senior Center, I hereby release Capital City Community Centers, its' directors, officers, employees, and all persons connected with the Center, from all liability for injury to myself. I authorize any physician selected by Capital City Community Centers to hospitalize and or to secure proper medical care for myself in the event that I am unable to grant permission in an emergency.

Signature _____

Date _____



Photography Authorization

I give my permission for Capital City Community Centers to photograph me while I am participating in program activities. I allow Capital City Community Centers to use such photographs in its literature and displays. I understand that the photos will not be sold or used for the financial gain of any individual but only for the promotion of programs and activities conducted by the Center, and hereby release Capital City Community Centers from any obligation to pay for the use of such photographs.

Signature _____

Date _____



Insurance Information

Medicare #: _____ Medicaide #: _____

Health Plan Name: _____

Health Plan ID #: _____

Additional Insurance Information:

Benefits Received

Social Security _____ SSI _____ Veteran's _____ Medicare _____

Medicaid _____ RIPAE _____ Food Stamps _____ Energy Asst. _____

Other _____

Activities of Daily Living

1 = No Assistance 2 = Some Assistance 3 = Much Assistance 4 = Cannot Perform

Circle One

Cooking	1	2	3	4	Housework	1	2	3	4	Managing Medicine	1	2	3	4
Phone	1	2	3	4	Shopping	1	2	3	4	Transportation	1	2	3	4
Reading	1	2	3	4	Writing	1	2	3	4	Personal Hygiene	1	2	3	4