Dear Caregiver, as part of our pre-admission process, we need certain information about the person with Alzheimer's disease or dementia. Please complete this form in its entirety and return to our office along with the Cost Share Assistance Application and the Physician Forms. Once this information is received, we will contact you to schedule an intake appointment.

Name of Person with Dementia: ____

Birth Date: ____

Insurance Provider: ____

Group Number: ____

Policy Number: ____

Medicare Number: ____

Social Security Number: ____

_______ Completed Cost Share Application/Please sign and date on the back of the form

_______ Physician form/Physician must complete and fax to the number on the bottom of the form

_______ TB test results/Skin test **or** negative chest x-ray that has been done within the past year

Signature of Primary Caregiver: ______________________________

Phone Number: ______________________