Granville HEALTH SYSTEM
Quality Care...Close To Home

HAROLD SHERMAN ADULT DAY CENTER
CONFIDENTIAL ANALYSIS WORKSHEET

Dear Participant and /or Caregiver,

This form is utilized by our program to determine whether you may qualify for assistance for grant funds available to adult daycare participants. Should you have any questions on how to fill out this form or would like our assistance in preparing this form, please contact 690-3273.

Participant Name: _____ Acct. #: _____
Address: _____
Home Telephone: _____ Date of Birth: _____
Social Security #: _____
Responsible Party: _____ Telephone: _____
Address: _____

Description of Income:	**Monthly Income Amount**:
Social Security Benefits	_____
Pension Income:	_____
VA Benefits:	_____
Dividends and Interest:	_____
Rental Income:	_____
Other Incomes- List:	
_____	_____
Total Income per Month:	**_____**

I understand that by filling out this application, I am requesting to receive assistance with payment of my fee to the Harold Sherman Adult Day Center program. I authorize Granville Health System to verify any information provided on this form. If I am provided assistance with this fee, I will be responsible for the remainder of the monthly balance. I agree to submit appropriate documentation to be used as verification of the above.

_____ _____
Participant's Signature Date

_____ _____
Responsible Party's Signature Date

For Office Use Only:
Total Monthly Income: _____

Participant is classified as: ☐ Day Care ☐ Day Health # of Days Weekly: _____

Amount or Percentage of Grant Funds: United Way Grant _____
Transportation Grant _____

Participant Responsible for: Daily Program Fee _____ Transportation fee _____

I have verified the information provided by the participant and recommend the above. Please initial.
Office Coordinator: _____ Director: _____ Date: _____