



Pre-Admission Application

Name: _____ Date: _____

Address: _____

County: _____

Telephone: _____

Date of Birth: _____

Reason(s) applying to Adult Day Health Center:

I understand that by signing this application, the above-named person is not guaranteed acceptance to the Meals On Wheels Atlanta Adult Day Health Center.

Signature (of individual completing application): _____

Name (printed): _____

Relationship to Applicant: _____

Email address: _____

Telephone: _____

*Please return this application to Brett Perriman, Meals On Wheels Atlanta,
1705 Commerce Drive NW, Atlanta, Georgia 30318 or
brettperriman@mealsonwheelsatlanta.org*