Friendship Café Application

Client Name: ____
(First) (Middle Initial) (Last)

Address: ____
(Street) (City) (State) (Zip)

Home Phone: ___________________________ Cell Phone: _____________________________

Email: ______________________________City or County of residence: __________________

Date of Birth: ________/________/_________ Age: _______________
Month Day Year

Living Arrangement: Own Private Residence With Family Other:_________________

Do you have your own transportation? YES ☐ NO ☐

Are you able to independently attend the café*? YES ☐ NO ☐

Do you have a Medicaid Personal Care Aide*? YES ☐ NO ☐

Emergency Contact Name: ____

Relationship: ________________________ Best Contact Phone: ___________________________

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Signature of Applicant Date

Please return completed application to Senior Connections in enclosed envelope or mail to

Senior Connections, Attn: Colleen Wilhelm

24 E. Cary Street, Richmond VA 23219

*Participants must be able to attend the café independently and without assistance. Participants diagnosed with Alzheimer's or other Dementia are not eligible to attend the Café. Participants who receive Personal Care Services through Medicaid are not eligible to attend the Friendship Café. Revised 01/05/2015.