At Home Membership Enrollment Form

Thank you for your interest in becoming a member of At Home. Please help us to serve you better by completing the following information. For further information contact: Director of Elder Services, Anne Ossanna at (207) 374-5612 or email Anne.Ossanna@dcpcap.org

Date: ___________________

PERSONAL INFORMATION

Name you go by_______________ Birth Name___________________
Date of Birth________________________
Street Address____
Mailing Address (if different)_______________________________________
Town____________________State______Zip________________
Telephone________________Cell Phone_______________________
Email____
Primary Care Physician_______________________________________
Power of Attorney____
MaineCare Recipient? YES or NO A current smoker? YES or NO
Advance Directives? YES or NO **if YES, please provide a copy of AD**

EMERGENCY CONTACTS

1) Name ______________________	2) Name______________________
Relationship__________________	Relationship________________
Address______________________	Address____________________
Town________________________	Town______________________
State__________ Zip__________	State__________Zip________
Phone________ Cell__________	Phone_________Cell________
Email_________________________	Email______________________

Local Directions to my home:
____
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SERVICES

Please indicate which services you wish to utilize from At Home

Basic Guaranteed Services: ***48 hour advance notice is required***

___ Transportation to medical appointments (4 rides per month within a 50 mile radius

___ Grocery and or pharmacy delivery (no alcohol or tobacco). Order must be called in and prepaid by member

____ Scheduled (twice monthly) non-emergency home health visits from a licensed health care professional for routine check-in and help with filling medications

____ Friendly phone calls

____ Home safety assessment

____ Information on local resources

____ Scheduled (once monthly) visit by a licensed social worker

Volunteer Services: ***Subject to volunteer availability***

Our volunteers will have a valid license, private auto insurance, backgrounds check, training an sign a confidentiality statement

____ Transportation for Errands, Activities and Shopping

____ Companionship

____ Technology Hookups

____ Support following hospitalization

____ Activities: educational programs, interest groups, social gatherings, exercise

Please describe any physical limitations you have (to determine whether or how drivers can safely transport you:
____
____

TO ENROLL AS A MEMBER AND MAKE A PAYMENT:

At Home determines membership fee based on yearly income

Annual Income: ___________________
Please Bill: (name) _________________________
(address) ________________________
(city, state, zip) ____________________
Bill: Monthly___ Quarterly___ Annually _____

Please include any additional information you would like to share: ____

____
(Printed Name) (Signature) (Date)

Please send completed form to:

Anne Ossanna
Friendship Cottage/At Home
PO Box 1107
Blue Hill, ME 04614

An invoice will be mailed to you from Downeast Community Partners. At Home is a program of Downeast Community Partners.

Annual Membership Fee __________
To be completed by At Home Staff