TeleCare Program

A Community Service of Benzie Home Health Care
P.O. Box 804, 209 S. Benzie Blvd.
Beulah MI 49617
(231) 882-5031

APPLICATION FOR SERVICES

Date:	Name:		
Street :			Phone #:
City:	Birth date:		Gender: M F
E-mail:			Marital Status:
If applicable, list mobile home park or apartment complex name: Name of Manager: Phone #:			
Living Arrangement: (i.e. lives alone; with family; etc.)			
Please list any medical concerns:			
Name and phone number of your doctor:			
Do you need a reminder to take your medications? Y N			
Do you have Lifeline? Y N			
What are your interests or hobbies?			
Do you have any pets? What kind?			
Emergency Contacts:			
Name:		Name:	
Address:		Address:	
Phone #:		Phone #:	
Relationship:		Relationship:	
Do either of your emergency contacts have a key to your home?			
If yes, who?			
How were you referred to the TeleCare Program?			

PLEASE COMPLETE NEXT PAGE

Telephone Reassurance Calls	
Calls are available between 9:00 and 10:30 a.m. daily. Do you have a time preference for calls? _________________________	
What other agencies are providing you with services? (i.e. Meals on Wheels)	
1)	
2)	
3)	
In requesting services from the TeleCare program, I understand that a confidential file will be kept including this application and other written notes regarding my history, health and general condition. This record is confidential and will be seen only by the staff and designated volunteers, and will not be released without my consent. These services are voluntary and I may cancel at any time. There is no cost for any services that the TeleCare program provides. I agree to hold harmless and release from liability any and all acts done in the course of service performed for me by Benzie Home Health Care, its employees or volunteers. Please sign this application and return it to receive services.	
Signature:	Date:

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Release of Information

CLIENT NAME: ____________________________________

In an effort to meet the needs of our clients, it is sometimes necessary to contract or collaborate with other community services and/or agencies. In the scope of coordinating these services, it is sometimes necessary to exchange or disclose personal or confidential information. The coordination of these services is intended to assist the clients of **TeleCare.**

I authorize the **TeleCare** program to obtain and/or disclose confidential Information to/from my physician or other community social service agencies.

______________________________________ __________________
Client's Signature Date

or ____________________________________ __________________
Legal Representative Relationship

Please return all 3 pages to Benzie Home Health Care in the enclosed postage paid envelope. Thank you!