



Eskaton Telephone Reassurance Program

5105 Manzanita Ave., Carmichael, CA 95608

Phone: 916-334-1072 Fax: 916-338-1248

Name:			Date:		
Street:			Phone #:		
City, State:		Zip:	Birth date:		Age:
E-Mail:			Marital Status:		
If applicable, list mobile home park or apartment complex name:					
Address:					
Name of Manager:					
Living Arrangement: (i.e. lives alone, with family, etc.)					
Primary Language:		Gender: M F		Ethnicity:	
Social Security Income:		SSI Income:		Total Monthly Income:	
Health Plan:			Are you a veteran? <input type="checkbox"/> yes <input type="checkbox"/> no		
Who is the physician you see most often? Please provide their name and phone number.					
Do you attend Adult Day Health Care? If so, what is their name and number?					
What is your primary hospital?					
Do you have a personal emergency response pendant?			If yes, with which hospital or agency?		
Emergency Contacts					
Name:			Name:		
Address:			Address:		
Primary Phone:		Secondary Phone:		Primary Phone:	
				Secondary Phone:	
Relationship:			Relationship:		
Do either of your emergency contacts have a key to your home?					
If yes, who?					

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How were you referred to the Telephone Reassurance Program? Please provide the name, address and phone number of the referral source:

Telephone Reassurance Calls

- Would you prefer calls daily? _____ 2-3 times a week? _____ 2-4 times a week? _____
- Calls are available between 8:00 a.m. to 2:00 p.m. daily.
- What is your time preference for calls? _____

What other agencies are providing you with services? (i.e. Meals On Wheels, IHSS)

1)

2)

3)

❖ In requesting services from the Telephone Reassurance 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 Program provides. ***Eskaton Telephone Reassurance is a social network and will not be held liable for your safety and welfare.***

Signature:

Date:



Release of Information

PARTICIPANT
NAME: _____

ADDRESS: _____

TELEPHONE: _____

BIRTH DATE: _____

In an effort to meet the needs of Participants, it is sometimes necessary to contact and share information with other community services and agencies. This may include the disclosure of personal or confidential information. Sharing this information is intended to assist Participants of the Program.

_____ I authorize Eskaton Telephone Reassurance Program to obtain and/or disclose confidential information to/from other community social service agencies.

Participant Signature

Date

or _____
Legal Representative

Relationship

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Welfare and Safety Check

In the event that we are not able to reach you by telephone after 48 hours, we may then contact local law enforcement and ask them to initiate a welfare and safety check. We will only take this course of action if we have not been able to reach available emergency contact numbers listed on your application. This means that the police will arrive at your home to make certain that you have not had an emergency.

Some participants do not wish us to notify the police under any circumstances. Please check below if this is your preference.

If you cannot reach me by phone or my contacts, and I have not called to say I would be away, please **do not** initiate a welfare and safety check.

❖ *Eskaton Telephone Reassurance is a social network and will not be held liable for your safety and welfare.*

NAME: _____
(Please Print)

SIGNATURE: _____ DATE: _____

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