Membership Enrollment Form

Thank you for your interest in becoming a member of At Home.
Please help us serve you better by completing the following information. For further information contact: Program Director, Rose Honders at (207) 374-5852
Email: Rose.Honders@downeastcommunitypartners.org

Date: _______________

Personal Information

Name you go by________________________________
Birth Name________________________________
Date of Birth________________________________
Street Address

____
Mailing Address (if different)

____
Town ________________________________
State ____________________ Zip____________
Telephone_______________ Cell_____________
E-mail________________________________
Primary Care Physician _____________________
Power of Attorney _________________________
MaineCare Recipient? Yes or No
Are you a current smoker? Yes or No
Advanced Directives? Yes or No

Significant Other____________________________
Birth Name________________________________
Date of Birth ________________________________
Street Address

____
Mailing Address (if different)

____
Town ________________________________
State _________________ Zip_______________
Telephone ____________Cell_______________
E-mail ________________________________
Primary Care Physician ____________________
Power of Attorney _________________________
MaineCare Recipient? Yes or No
Are you a current smoker? Yes or No
Advanced Directives? Yes or No

Contacts

1) Name ________________________________
Relationship____________________________
Address ________________________________
Town ________________________________
State____________________ Zip____________
Telephone______________ Cell____________
E-Mail ________________________________

2) Name ________________________________
Relationship____________________________
Address________________________________
Town________________________________
State__________________Zip____________
Telephone_____________ Cell_____________
E-Mail ________________________________

Local Directions and Number on my (our) home:

____
____
____

Services

Please indicate which services you wish to utilize:

Guaranteed Services: *48 hour advance notice is required, appointments must be made before 3:30 as our office close at 4:00)*

- ☐ Transportation to medical appointments (4 rides per month within a 40 mile radius)
- ☐ Initial home safety and accessibility assessment
- ☐ Information on local resources
- ☐ Scheduled, (twice monthly) non-emergency home health visits from a licensed health care professional for routine check-ins and help with filling medication boxes.
- ☐ Transportation to grocery store/grocery delivery

Volunteer Services: *subject to volunteer availability*

Our volunteers have a valid license, private auto insurance, background checks, and sign a confidentiality agreement.

- ☐ Friendly Phone Calls
- ☐ Library Services/reading
- ☐ Support following hospitalization
- ☐ Companionship
- ☐ Card & Letter Writing
- ☐ Shoveling, gardening
- ☐ Occasional meal preparation
- ☐ Technology support
- ☐ Small house chores & maintenance (light bulbs, smoke alarm batteries, etc.)

Referral Services:

At Home can provide contact information for local service providers that members may contract and pay directly for services:

- ☐ Home maintenance (plumbing, electrical, lawn mowing, snow shoveling, etc.)
- ☐ Household assistance (cleaning, meal prep, chores, etc.)
- ☐ Professional computer technicians
- ☐ Licensed home health care

TO ENROLL AS A MEMBER AND MAKE PAYMENT:

At Home determines membership fee based on yearly income.

Annual Income:_______________________________

Yearly Fee:__________________________________

Start Date:__________________________________

Please Bill: (name) ____

(address)____

(city, state, zip) ____

Please include any information you would like to share

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____

(Printed Name) *(Signature)*

____

(Printed Name) *(Signature)*

Please send completed enrollment form to:

At Home
P.O Box 1184
Blue Hill, Maine 04614

At Home is a program of Downeast Community Partners