

LIFELINE APPLICATION INFORMATION: Please fill out the following information and return to North Memorial Lifeline. Or, call our local office Monday – Friday between 8-4 to process the application via telephone. Please allow a minimum of 3 business days to process.

**SUBSCRIBER DEMOGRAPHIC INFORMATION**

NAME: _____ BIRTH DATE: _____ Male/Female (please circle)

TELEPHONE REQUIREMENTS

IT IS PREFERRED FOR SUBSCRIBER TO HAVE (PLAIN OLD TELEPHONE SERVICE) for optimal service.

At this time Lifeline is not compatible with cellular telephone services.

Subscribers Phone Service Company: _____

Is there a computer in the home? _____ Yes _____ No Dial Up or DSL

HOME TELEPHONE # _____ Landline or VoIP (bundled) service

Do you need to dial a number such as an 8 or 9 to get an outside line before you dial a number? If yes, what number is needed? _____ Alternate Subscriber Phone #: _____ (cell/work)

SUBSCRIBER ADDRESS: _____

Apartment Name & # _____

City/Zipcode _____

HIDDEN KEY INFORMATION: *To prevent a forced entry, We strongly urge you to consider hiding a key or getting a key box. WE ARE NOT responsible for any damages as a result of a forced entry by 911.*

Hidden key location/Key Box Code: _____

LANGUAGE Does the subscriber speak and understand English? YES NO

What language(s) does the subscriber speak & understand? _____

APPLICATION/INSTALLATION APPT. CONTACT *(If different from subscribe.)*

Who should we call to answer questions regarding this application and/or to schedule installation appointment?

Name _____ Phone: _____

Relationship to Subscriber: _____



3300 Oakdale Avenue North
 Robbinsdale, MN 55422
 763-520-5911

Please list subscribers **primary medical conditions.** (e.g. heart disease, diabetes, asthma, falling, etc.)

PRIMARY CARE DOCTOR NAME & PHONE #: _____

PREFERRED HOSPITAL: _____

Does anyone live with subscriber? _____ Yes _____ No (List Names and relationship)

Who recommended you to our program? How did you hear about North Memorial Lifeline?

PAYER INFORMATION IF DIFFERENT FROM SUBSCRIBER

We DO NOT bill Medicare or Private Medical Insurance. If you are MA and on a waived service program, please have your case management worker call our office with the waived service billing information. E.g. Elderly Waiver, CADI, Alternative Care, Minnesota Senior Health Options

Are you on Medical Assistance? _____ Yes _____ No

Are you on waived services? _____ Yes _____ No Which waiver are you on? _____

Elderly Waiver, Alternative Care, CADI, Traumatic Briain Injury, Other? _____

PAYER NAME (IF DIFFERENT FROM SUBSCRIBER): _____

ADDRESS: _____

PHONE #'S: _____

What is the name of your Care Coordination worker? _____

If paying by credit card: We bill for month previously past. Eg. December service will be billed in January. We accept Visa or MasterCard. Payment coupons will be provided at the time of install.

The billing cycle is from the first of the month through the end of the month and starts with the month the service was activated/set up and ends when services are discontinued and our equipment has been returned back to our program. The entire months payment is due whether or not the service is installed on the first or the 25th of the month. We do not pro-rate any of our fees. Please call our office if you have any billing questions/concerns.

MISCELLANEOUS INFORMATION

Is subscriber on Hospice? _____ Yes _____ No Hospice Name: _____

Does subscriber have DNI/DNR orders? _____ Yes _____ No

Please POST any Healthcare Directives, DNI/DNR orders and a dated a list of any medications or allergies on the refrigerator or in a clearly marked medical folder information by the refrigerator.

Is subscriber on kidney dialysis? _____ Yes _____ No

If Yes, When-What days and times? _____

Does Subscriber regularly go to a day care program? _____ Yes _____ No If Yes,

Day Care Name &Phone #: _____

What days and times? _____

Does subscriber smoke? _____ Yes _____ No

Does anyone else smoke in the home? _____ Yes _____ No

Does subscriber use oxygen? _____ Yes _____ No

Oxygen Company Name: _____

Are there any pets in the home? _____ Yes _____ No

List of Pets: _____

We ask that when our installer comes out to install our Lifeline equipment or makes a service call that your pets are kept locked up.

Circle all subscriber uses: CANE WHEELCHAIR SCOOTER WALKER

MONTHLY TEST

We request that you press the Lifeline button at least once a month to check in with us and to ensure the equipment is in good working order. Because it may be difficult for the subscriber to remember to perform the monthly test, please provide name of contact who will take responsibility to make sure the test is performed each month:

Name _____

Phone: _____

RESPONDER/EMERGENCY CONTACT INFORMATION

We ask that you provide us with 2-3 contacts other than 911 whom we can call upon to assist you.

- *You must get permission from all of your responders to list them.*
- *Your responders agree to check on you if we call them and/or if your power or telephone service is not working.*
- *Responders should live about 10-20 minutes from you and have access to your home.*
- *List responders in the order you wish them to be called. We accept cellular, home and work phone numbers. We cannot accept pager numbers.*
- *We recommend that your responders have access to your home.*

Responder Contact #1
Emergency Notify? Yes / No

Name	Home Phone: ()
Address	Work Phone: ()
	Cell Phone: ()
Relationship	Keys: Yes/No

Responder Contact #2
Emergency Notify? Yes / No

Name	Home Phone: ()
Address	Work Phone: ()
	Cell Phone: ()
Relationship	Keys: Yes/No

Responder Contact #3
Emergency Notify? Yes / No

Name	Home Phone: ()
Address	Work Phone: ()
	Cell Phone: ()
Relationship	Keys: Yes/No

Is there any other information we should be aware of?

What days/times work best for our installers to come out to your home to install our equipment?