PLEASE SUBMIT COPIES OF MEDICARE CARD, MASS HEALTH CARE, ANY TYPE OF INSURANCE CARD

FAMILY AND COMMUNITY INVOLVEMENT

FAMILY / FRIENDS:

NAME:_____ ADDRESS:_____
(street) (city) (state) (zip)
RELATIONSHIP:_____ PHONE #_____
(home) (work)

NAME:_____ ADDRESS:_____
(street) (city) (state) (zip)
RELATIONSHIP:_____ PHONE #_____
(home) (work)

NAME:_____ ADDRESS:_____
(street) (city) (state) (zip)
RELATIONSHIP:_____ PHONE #_____
(home) (work)

(LIST OTHER RELATIVES OR CLOSE FRIENDS ON REVERSE SIDE)

IS THERE A LEGAL GUARDIAN? YES / NO NAME:_____

WHO IS TO BE CONSIDERED SPOKESPERSON FOR THE FAMILY:_____

DOES THE APPLICANT HAVE ANY OF THE FOLLOWING SERVICES?

HOMEHEALTH AIDE: _____ HOMEMAKER:_____ VISITING NURSE:_____

SOCIAL WORKER:_____
(name) (agency)
ADULT DAY HEALTH:_____
(location)

MEALS ON WHEELS: _____ OTHER:_____
(specify)

APPLICANT'S PRESENT LIVING SITUATION: OWN HOME: _____ RENTS:_____

APT:_____ ELDERLY HOUSING:_____ REST HOME:_____

DOES APPLICANT LIVE: ALONE:_____ WITH SPOUSE:_____

WITH OTHERS:_____ SPECIFY:_____

LENGTH OF TIME IN THIS ARRANGEMENT:_____