

# LIFELINE APPLICATION

Please complete this form (front and back) accurately and completely. If you are unable to answer a question, please call 631-5432 and we will help answer any questions you may have.

Please return the completed (pink) Lifeline form to:

St. Gabriel's Hospital, Lifeline Program, 815 Second Street SE, Little Falls, MN 56345

We will then contact you to set up a convenient date and time to install the Lifeline unit. Thank you.

Name and Address:  
(Print Clearly)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Apartment #  
\_\_\_\_\_ Zip Code

Birth Date \_\_\_\_\_ Your Telephone Number \_\_\_\_\_

Reason you want Lifeline - Basic medical criteria: \_\_\_\_\_

Do you require: \_\_\_\_\_ Insulin \_\_\_\_\_ Nitrogen \_\_\_\_\_ Oxygen

Closest relative to contact: Name \_\_\_\_\_ Phone Number \_\_\_\_\_

What city do you live within? (if applicable) \_\_\_\_\_ Which county do you live in? \_\_\_\_\_

Please provide detailed directions to your home: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of your telephone company: \_\_\_\_\_

How many telephones do you have? \_\_\_\_\_

What kind of telephone do you have? \_\_\_\_\_ Wall \_\_\_\_\_ Desk or Table

The Lifeline machine will be connected to one of your telephones. In what room is that telephone located?

\_\_\_\_\_

How is that telephone connected to the wall? \_\_\_\_\_ Wall Phone \_\_\_\_\_ Modular Jack  
\_\_\_\_\_ Four-prong Jack \_\_\_\_\_ Hard Wire (no plug)

Do you have a 3-prong grounded electrical wall outlet within four feet of that telephone? \_\_\_\_\_

Can this wall outlet be turned off by a wall switch? \_\_\_\_\_ YES \_\_\_\_\_ NO

Who referred you to Lifeline? \_\_\_\_\_ Doctor \_\_\_\_\_ Social Worker \_\_\_\_\_ Home Health \_\_\_\_\_ Family \_\_\_\_\_ Other

What type of personal help button do you prefer? \_\_\_\_\_ Necklace \_\_\_\_\_ Wrist

**Please list the names, addresses, home phone numbers, work phone numbers and cell phone numbers of your three responders. These responders will need to be provided with access to a key to your home in order to answer any potential "Help Call" 24 hours a day.**

*(ACCESS TO A KEY IS ESSENTIAL)*

Responder #1  
*(Print Clearly)*

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Relationship (daughter, son, neighbor, friend...) \_\_\_\_\_

Does this Responder have access to a key to your home? \_\_\_\_YES \_\_\_\_NO

Responder #2  
*(Print Clearly)*

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Relationship (daughter, son, neighbor, friend...) \_\_\_\_\_

Does this Responder have access to a key to your home? \_\_\_\_YES \_\_\_\_NO

Responder #3  
*(Print Clearly)*

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Relationship (daughter, son, neighbor, friend...) \_\_\_\_\_

Does this Responder have access to a key to your home? \_\_\_\_YES \_\_\_\_NO

- ◆ Name of your Family Physician \_\_\_\_\_
- ◆ Clinic Name/Address \_\_\_\_\_  
\_\_\_\_\_

- Do you have any questions regarding Lifeline Subscriber Lease Agreement? \_\_\_\_YES \_\_\_\_NO
- Who will be responsible for the payment of the Lifeline Services? Self \_\_\_\_ Other \_\_\_\_

If other, please indicate name and address or organization (if applicable): \_\_\_\_\_

- 
- ❖ Would you and/or a loved one be willing to complete your own monthly test calls for ongoing maintenance of your Lifeline machine? \_\_\_\_\_Yes \_\_\_\_\_No
  - ❖ Would you like information on the Senior Companion Program (Ext. 5611) which involves friendly phone calls and home visits by a Senior Companion? \_\_\_\_\_Yes \_\_\_\_\_No

**Thank you for choosing Lifeline!**