Telephone Reassurance Program

Application

Date: ______________________

Referred by: ______________________

Name of Client: ______________________

Date of Birth: ______________________

Address: ______________________

City: ____________ Zip Code: __________

Phone: ______________________

Race: Please check:

☐ African American ☐ Asian ☐ Hispanic

☐ American Indian ☐ Hawaiian/Pacific Island

☐ White ☐ Other

Ethnicity: Please check:

☐ Hispanic/Latino

☐ Non-Hispanic/Latino

Gender:

☐ Female ☐ Male ☐ Other

Living Arrangement:

☐ Live Alone

☐ Live with Others

Income: Check appropriate box:

Single, income at or below $1,304.00/month

☐ Yes ☐ No

Live with spouse, income at or below $1,762.50/month

☐ Yes ☐ No

Marital Status: Check appropriate box:

☐ Married ☐ Single

☐ Separated ☐ Widowed

List Medical Issues & medications (including insulin)

____

____

____

Use oxygen? Yes ☐ No ☐

Live alone? Yes ☐ No ☐

Use wheelchair/walker/cane? Yes ☐ No ☐

Fan or air conditioner in house? Yes ☐ No ☐

Do you drive a car? Yes ☐ No ☐

If yes, where do you keep it parked?

____

If yes, what is license plate number?

____

Do you use an answering machine? Yes ☐ No ☐

If you attend a senior activity center, which one?

____

Calls are made between 8:00 - 10:00 a.m.

Select the time your prefer to be called.

☐ 8:00 - 8:30 a.m. ☐ 9:00 - 9:30 a.m.

☐ 8:30 - 9:00 a.m. ☐ 9:30 - 10:00 a.m.

Select the days you prefer to be called

☐ Sunday ☐ Thursday

☐ Monday ☐ Friday

☐ Tuesday ☐ Saturday

☐ Wednesday

I agree to receive daily well-check calls and
I understand that:

- Calls are made seven (7) days a week, including holidays.
- I will receive a daily phone call from the Telephone Reassurance program.
- If my Telephone Reassurance Volunteer and my emergency contacts cannot reach me, the Police will perform a wellness check.
- I will interact with multiple volunteers, establishing a daily caring community connection and a safety check-in.

Signature: ______________ Date: ________

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Emergency Contact Plan of Action (POA)

List emergency contacts who are available and you have given consent to check on you. In the event the Telephone Reassurance Volunteers cannot reach you, these contacts will be called. If your emergency contacts cannot reach you, the Police will be asked to perform a wellness check.

Name ______________________________

Address ______________________________

Phone #1 ______________ #2 ______________

Email: ______________________________

Relationship to you? ______________________________

Does this contact have a key? Yes ☐ No ☐

Name ______________________________

Address ______________________________

Phone #1 ______________ #2 ______________

Email: ______________________________

Relationship to you? ______________________________

Does this contact have a key? Yes ☐ No ☐

Name ______________________________

Address ______________________________

Phone #1 ______________ #2 ______________

Email: ______________________________

Relationship to you? ______________________________

Does this contact have a key? Yes ☐ No ☐

Please send completed applications to:

caregiver_support@aacounty.org
OR mail to:
Department of Aging & Disabilities
ATTN: Telephone Reassurance
7320 Ritchie Highway, Glen Burnie, MD 21061

The Department of Aging and Disabilities receives state and federal grants to support the programs that are offered. Collection of demographic information is done for grant reporting purposes. Individual names are NOT reported, only demographic fields. While providing this information is not required to register for the program, we would appreciate it if you would provide the information to help support the grant reporting process. All information provided is kept confidential.