|  |  |  |
| --- | --- | --- |
| Contact Us: [www.alltbi.com](http://www.alltbi.com) | info@alltbi.com Tel: 516-747-2600 Fax 888-894-0540 | Visit Us: **Long Island**  753 Franklin AvenueGarden City, NY 11530  | Visit Us: **New York City**247-07 Jamaica Avenue Bellerose, NY 11426  |

**ALLIANCE PRIVILEGE PROGRAM**

**NEW SERVICE RECIEPIENT REGISTRATION**

**□ Cognitive Pro Track □ Garden City Senior courtesy mailbox/ Transportation**

|  |  |
| --- | --- |
| **Date:** |  |
| **Name:** |  | Phone  |  |
| **Address:** |  |
| **e-Mail:** |  |
| **Date of Birth:** |  | **SSN:** | * -
 |
| **Status (circle one)** | □ Married □ Widowed □ Single □ Divorced □ Separated □ Partnered  |
| **Who referred you?** **How did you hear about us?**  | □ Family/ Friend/ Referral Source:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ TV/ Video □ The Garden City News □ The Village of GC □ The GC Chamber of Commerce  |
| **Service Recipient former Occupation:**  |  |
| **Service Recipient former Employer:** |  |
| **Service Recipient former School:** |  |
| **Highest level of Education:** |  |
| **For Emergency, please contact:**  |  | **Relationship:** |  |
| **Phone:**  |  | **e-Mail:** |  |
| **Name(s) of Family members that live with me? (Name, Relationship & Ages)**  |  |
| **Any Fall History?**  | **□ Yes**  □ **No, If yes, describe and provide date of last fall? Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Allergies:** | **□ Or “No Known Drug Allergies” (NKDA)** |
| **Check off only what applies to you AND fill out sections below:**  | **□ I take No Medications at all □ I have never had ANY Surgery □ I have no medical conditions**  |
| **Medical Condition(s):** |  |
| **Current Medications:** |  |
| **Past Medical History:** |  |
| **Past surgical History:**  |  |
| **First time receiving care at home?**  | X **Yes □ No,** **If No, please provide the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Agency Name date of last home care visit?** |
| **What is the primary reason for your visit with us today?** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Complete the Service Request Sheet attached.**  |
| The **Introductory Rate(s) for services start at $24.95 per hour** based on need and ends after 30 days**.** A $595 deposit is required to schedule the initial home visit and Care Professional interview. We reserve the right to charge $95 for the cancellation of initial scheduled visit if 24 hour notice is not given.  |
| **REQUESTED SERVICE SCHEDULE** |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
|  |  |  |  |  |  |  |

**Total Hours Requested:** \_\_\_\_ hrs

**PAYMENT INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name:** |  | **Last Name:** |  |
| **Address:** |  |
| **Card Number\*:** | **□Visa □MC □Amex □Discover #:** |
| **Expiration:** |  | cvc |  |

\* All major Credit Cards are accepted. Please Note: There will be a 3% Convenience Fee for all credit card payments.

**We keep your payment information on file to charge you for any future visits you may schedule and to verify your identity. I hereby authorize Alliance Services for TBI to charge my credit card.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CARE COORDINATOR’S VISIT: (Date & Time\*)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  | **Time:** |  |

\*\*Cancellations must be provided up to 14 days in advance of a scheduled visit without charge.

**VISIT LOCATION:**

|  |  |
| --- | --- |
| **Address:** |  |