|  |  |  |
| --- | --- | --- |
| Contact Us:    [www.alltbi.com](http://www.alltbi.com) | [info@alltbi.com](mailto:info@alltbi.com)  Tel: 516-747-2600  Fax 888-894-0540 | Visit Us:  **Long Island**  753 Franklin Avenue  Garden 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:** |  |