

**2011 LIFELINE
NEW APPLICANT
INCOME, AGE, AND HOUSEHOLD SIZE VERIFICATION**

This form must be filled out and the appropriate documentation must be provided.

TOTAL HOUSEHOLD SIZE _____

SELF-DECLARATION OF HOUSEHOLD INCOME

The total household income received in the past twelve (12) months was \$_____. I understand that "income" means all of the money received by anyone in my household including, but not limited to:

- | | |
|------------------------------------|-----------------------------------|
| 1.) Gross Payroll (pre-tax amount) | 2.) Unemployment Benefits |
| 3.) Worker's Compensation | 4.) Social Security Income |
| 5.) Child Support | 6.) Alimony |
| 7.) Inheritance | 8.) Pensions and Annuity Payments |
| 9.) Any Untaxed Income | |

I further state that the sources of all income, including the time periods in which I received these sources, are listed in detail below*:

Federal program guidelines define a household as all people living in the same house, regardless of whether you maintain separate finances.

<u>PERSON</u>	<u>INCOME TYPE</u>	<u>AMOUNT (\$)</u>	<u>TIME PERIOD RECEIVED</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If additional space is needed, please attach extra pages.

I verify that all of my statements on this form are true and correct. I realize that I can be held liable under Federal and/or State law for making any knowingly false or fraudulent statements.

SIGNATURE: _____

PRINT NAME: _____

ADDRESS: _____

PHONE NUMBER(S) _____

***Documentation supporting the above disclaimer must be attached. Income verification should be provided in the form of the most recent social security statements, wage statements, income tax returns and/or bank statements containing the company/agency name and direct deposit amounts. Age verification should be provided in the form of a driver's license, state identification card or birth certificate photocopy.**

2011 PARTICIPANT SURVEY

(For Federal Reporting Purposes—in order to be eligible for free service you must complete the following information)

Name: _____

Address _____

City _____ Zip Code _____

How many people reside in your home? _____

Do you have a female as the head of your household? _____yes _____no

Income

What is your gross household monthly income? _____

What is your gross household yearly income? _____

Race/ Ethnicity

Do you consider yourself to be of Hispanic descent? Yes _____ No _____

Do you consider yourself to be one race or multiple races? One _____

Multiple _____

What race do you consider yourself to be? Please check one:

RACE:

_____ White

_____ Black/African American

_____ Asian

_____ American Indian/ Alaskan Native

_____ Native Hawaiian/ Other Pacific Islander

_____ American Indian/ Alaskan Native & White

_____ Asian & White

_____ Black/African American & White

_____ American Indian/ Alaskan Native & Black/African American

_____ Other: _____

Please submit the information to:

Lifeline

Attn: Brandy Cramer

703 S. Main St. Suite 211

Akron, Ohio 44311

LIFELINE APPLICATION

MAIL TO: LIFELINE
703 S. Main Street
Suite 211
Akron OH 44311

CALL: 330-762-0308
800-944-0308
FAX: 330-315-1392

1. HOUSEHOLD INFORMATION

NAME				SEX: <input type="checkbox"/> M <input type="checkbox"/> F		DATE OF BIRTH	
ADDRESS				APT		COUNTY	
CITY		ZIP	TOWNSHIP	HOME PHONE		CELL PHONE	
COMPLEX OR BUILDING NAME			KEY or LOCKBOX LOCATION (To prevent the police from forcing entry during an emergency or false alarm.)				

2. MEDICAL INFORMATION: Please include as much information as possible.

DESCRIBE YOUR MEDICAL CONDITION OR ANY DISABILITIES:						
<input type="checkbox"/> DO YOU TAKE A BLOOD THINNER?	NAME?	<input type="checkbox"/> DO YOU USE OXYGEN?				
CHECK ALL THAT APPLY:						
<input type="checkbox"/> CANE	<input type="checkbox"/> QUAD CANE	<input type="checkbox"/> WALKER	<input type="checkbox"/> WHEELCHAIR	<input type="checkbox"/> ELEC. SCOOTER	<input type="checkbox"/> BEDBOUND	<input type="checkbox"/> OTHER:
PHYSICIAN		PHONE		PREFERRED HOSPITAL		

4. EMERGENCY CONTACT: Whom do you want notified if you are taken to the hospital?

NAME			RELATIONSHIP			
ADDRESS		CITY		STATE	ZIP	
PHONE		WORK PHONE		CELL PHONE/PAGER (Circle)		

5. RESPONDERS: These are family, friends or neighbors called to check on you if you do not respond during an alarm. They must live within 15 mins.

1	NAME				RELATIONSHIP	
	PHONE		TYPE	PHONE	TYPE	KEY <input type="checkbox"/> YES <input type="checkbox"/> NO
2	NAME				RELATIONSHIP	
	PHONE		TYPE	PHONE	TYPE	KEY <input type="checkbox"/> YES <input type="checkbox"/> NO

6. PAYER: Whom should we bill for your monthly Lifeline service?

NAME		RELATIONSHIP		HOME PHONE	
ADDRESS					
CITY				STATE	ZIP

7. PLEASE ANSWER THE FOLLOWING QUESTIONS

Who referred you or informed you of Lifeline?			
NAME	RELATIONSHIP/AGENCY		PHONE
Whom should we contact to schedule the installation or to obtain further information?			