

**Please Print clearly or type.**

All details are kept confidential to assist you and Loved One.

**Your Contact Information**

Name	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
Cell Phone	
E-Mail Address	

**Your Loved One's Information**

First Name	
Middle Initial	
Last Name	
Home Phone	
Work/Cell Phone	
Street Address	
City ST ZIP Code	
Your relationship to Loved One	

**Service Details (Please attach additional sheet(s) with more details and please give dates and time for all outside activities).**

UNLESS OTHERWISE REQUESTED, ALL DAILY CALLS TO LOVED ONE'S HOME ARE MORNING, NOON-TIME AND AFTERNOON, DURING BUSINESS HOURS.

IF NOT IN EASTERN STANDARD TIME ZONE THEN PLEASE GIVE THEIR RELEVANT TIME ZONE \_\_\_\_\_

**SERVICE DETAILS**

<b>LIVING ESSENTIALS</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
Medications					

Service Details

<b>Check Blood Pressure</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>Diet</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
Check Blood Sugar					
Insulin					
Vitamins					
Fiber					
Herbs/Supplements					

Doctor Appointments  
 Prescription Refills  
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 \_\_\_\_\_  
 \_\_\_\_\_  
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**SERVICE DETAILS**

<b>PERSONAL CALENDAR</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
Wake Up					
Check Up call					
Dance					
Exercise, Tai Chi, Yoga					
Salon, Hair care					
Phone calls					
Chat session					
Walk					
Pet care					
Schedule Confirmation					
Homemaker					
Visiting Nurse					
Meals on Wheels					
Day Care					
<b>CHORES</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
Cleaning					
Laundry					
Shopping					
Washing					
Dry Cleaning					
<b>ENTERTAINMENT</b>					
Favorite TV or					
Radio Shows					
Newspapers					
Magazines					
Puzzles					
Books					
Trips					

**(Please attach additional sheet(s) with more details.)**

Loved One's Name \_\_\_\_\_

**Health Status/Medical Condition, if yes please give details below.**

Medic-Alert ID Card? Yes  Allergies to Drugs? Yes

Advanced Medical Directive or Living Will? Yes  \_\_\_\_\_

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Primary Physician's Name, Phone, Address

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**If there is no answer on the phone, what warrants a health crisis (Emergency) in your estimation?**

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**If needed what emergency contacts do you wish us to make?**

**Their Local Emergency Contacts (Please list in order of calling)**

For EMS ("911")-need the loved one's local emergency service number. ("911" will call our local EMS not theirs)

	Do any of below have key <input type="checkbox"/> access?	
Name	Phone	Key <input type="checkbox"/>
1 _____		<input type="checkbox"/>
2 _____		<input type="checkbox"/>
3 _____		<input type="checkbox"/>

**Special Services: Please attach additional information. Commonly a limited power of attorney for the specific circumstance is required.**

- A  Assistance with writing or form completion, compiling information
- B  Bill sorting coordination of bills to benefits
- C  Consulting with Medical Staff on a limited basis
- D  Medical Billing Problem Resolution
- E  Negotiating with insurance companies for eligible benefits

**Do you have any power of attorney?**  No  Yes \_\_\_\_\_

**Optional Services,**

Birthday/Anniversary reminders, up to 2 No Fee.


- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

- Presidential greetings arranged
- Gift Suggestions, Book and Film Finding (Purchasing at additional cost)
- Special discussions of Old Time Radio, early Films, early Television

**Signature**

By submitting this application, I affirm that the facts set forth in it are true and complete.  
 I understand that if I am accepted as a client, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate cancellation.  
 This application will be considered part of the agreement, which client and loved one should sign.  
 There is no independent investigation; actions are entirely based on loved one's verbal answers.  
 At this time only loved ones whose primary language is English can be accommodated.  
 For protection and assurances all calls between client, loved one and third parties are to be recorded.

Client 's Name (printed)	
Signature	
Date	
Love One's Name (printed)	
Signature	
Date	

*Personal Voice Inc.*  Your forget-me-not service in the computer age  
1-USS-4-GET-ME-NOT. 1-877-443-8636 APPLICATION