



ShareCare™ of Leelanau, Inc.

211 S. High Street ♦ P.O. Box 153
Northport, Michigan 49670-0153
231-386-2273 ♦ 231-386-0016 FAX

Office Use

Date Updated: _____

Enrollment Date: _____

Member # _____ Classification: _____ Region: _____

ENROLLMENT INFORMATION

Name: _____

Phone: (_____) _____

Mailing Address: _____

Cell Phone (_____) _____

Street Address: _____

E-mail: _____

City: _____ State: _____ Zip: _____

Wint. Address: _____

In what school district do you live? _____

Wint. City: _____ State: _____ Zip: _____

Birth date: _____ / _____ / _____

Wint. Phone: (_____) _____

Spouses Name: _____

Medicare or other #: _____

Church Affiliation: _____

Employer (former): _____

Directions to your home: _____

EMERGENCY CONTACT

Name: _____

PRIMARY FAMILY REPRESENTATIVE

(i.e.: Eldest child or patient advocate)

Name: _____

Home Phone: (_____) _____

Home Phone: (_____) _____

Other Phone: (_____) _____

Other Phone: (_____) _____

Relationship: _____

Relationship: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Primary Physician: _____ Phone: (_____) _____

Other Physician(s): _____ Phone: (_____) _____

CHILDREN OR CLOSE RELATIVES

Name/Relationship	Address	Phone Numbers
-----		Home (_____) _____ Other (_____) _____
-----		Home (_____) _____ Other (_____) _____
-----		Home (_____) _____ Other (_____) _____

MEDICAL INFORMATION

Are you presently under medical treatment? Circle those that apply: Hypertension, Lung Condition, Cancer, Diabetes, Stroke, Heart Condition, Arthritis, Glaucoma, Digestive Disorder, Problems with Ambulation.

Other: _____

Do you have a pacemaker? Yes () No ()

Please list all medications: _____

Do you have any drug allergies? _____

Do you have any food allergies? _____

Do you believe you will need any of the services ShareCare offers in the near future? Yes () No ()

If yes, in what way? _____

Do you have Health Insurance? Yes () No () Do you have Prescription Coverage? Yes () No ()

Do you have a Medical Durable Power of Attorney/Advanced Medical Directive? Yes () No ()

Where is it on file: _____ Who is your advocate: _____

Alternate advocate: _____

Please attach a copy of your MDPA or Advanced Directive if you wish us to keep it on file in case of an emergency.

MISCELLANEOUS INFORMATION

Do you live alone? Yes () No () If no, person with whom you live: _____

Nearest Neighbor: _____ Phone: (____) _____

Do they have keys to your home? Yes () No ()

Most ShareCare services will be arranged at your request and with your participation. However, during an illness or an emergency, if you cannot be consulted but need help, we will be glad to call people you already use and prefer. Please list them below; otherwise we will contact providers with whom we have contracted and they will bill you directly.

Service	Who	Phone Number
Heating/Fuel Oil	_____	(____) _____
Plumbing	_____	(____) _____
Electric	_____	(____) _____
Snow removal	_____	(____) _____
Lawn Care	_____	(____) _____
Trash pick-up	_____	(____) _____
Housekeeper	_____	(____) _____
Handyman	_____	(____) _____
Window washer	_____	(____) _____
Other	_____	(____) _____