

Reading Response Program Eligibility Application – Three page form

- | | | |
|---|--|--|
| <input type="checkbox"/> LifeLine
Hallmark Health System, Inc.
239 Commercial St.
Malden, MA 02148
781-338-7800 | <input type="checkbox"/> Medication Dispensing
C/O LifeLine
Hallmark Health System, Inc.
239 Commercial St.
Malden, MA 02148
781-338-7800 | <input type="checkbox"/> Medical Transportation Program
Reading Elder Human Services
16 Lowell St.
Reading, MA 01867
781-942-6659
<input type="checkbox"/> ESCORT REQUEST
(list details on page 3) |
|---|--|--|

Name: _____ Phone: _____
Address: _____ Date of Birth: _____
Soc. Sec. #: _____ Number of people in household: _____

Emergency Contacts:

Name: _____ Phone: Home: _____ Work: _____

Address: _____ Relationship: _____

Name: _____ Phone: Home: _____ Work: _____

Address: _____ Relationship: _____

Primary Care Physician: _____ Phone: _____

Primary Care Address: _____

Hospital Preference: _____ Phone: _____

Health Insurance Coverage:

Medicare # _____ Circle all that apply: A B Mass Health # _____

MassHealth clients need to submit the names and addresses of all their doctors so we can send the doctors the PT-1 Form required by MassHealth for transportation.

Other Insurance, HMO: _____ Veteran Status: _____

Limitations: (circle all that apply) Homebound – Hearing – Vision – Speech - Mental Health - Ambulation - Other

Do you use adaptive equipment (circle all that apply) wheelchair walker cane other _____

Please be aware that the medical taxi drivers are under no obligation to transfer wheelchairs, or to give physical assistance. If there is a need for this service, a special request must be made at the time of request for transportation and it will be determined if this need can be met.

Additional Information: _____

SPECIAL CONSIDERATIONS

Signature: _____ Date: _____

Reading Response Representative: _____ Date received: _____

Reading Response Program Eligibility Application
Cont.

Gross Monthly Household Amount:

- | | |
|--|-----------|
| 1. Social Security | 1. _____ |
| 2. Pension | 2. _____ |
| 3. SSI | 3. _____ |
| 4. VA | 4. _____ |
| 5. Dept. of Transition Assistance, i.e. Food Stamps..... | 5. _____ |
| 6. Employment | 6. _____ |
| 7. Family Support | 7. _____ |
| 8. Interest Income | 8. _____ |
| 9. Dividends/Annuities | 9. _____ |
| 10. Other | 10. _____ |

Gross Monthly Income From All Sources: _____

Yearly Income From All Sources: _____

Applicant signature: _____ Date: _____

Reading Response Representative: _____ Date: _____

Reading Response Program Eligibility Application, Cont.

ESCORT REQUEST

Name: _____

Home address: _____ Reading, MA 01867

Phone number: _____

Family member/contact: _____

Family member/contact phone: _____

Procedure: _____

Date of procedure: _____ Time: _____

Location of procedure: _____

Do you use portable oxygen? _____

Equipment: wheelchair walker cane other _____

Special considerations: _____

Reading Elder Services Representative Please fax to:

Hallmark Health VNA & Hospice, Inc.; 178 Savin St.; Malden, MA 02148

FAX 1-781-338-7840

ATTN: Home Health Aide Department; Judy Keogh, Supervisor

Faxed by: _____ Date faxed: _____

This form will be sent with ESCORT on day of procedure