Date:
How did you learn about ElderBridge SoCal?

ENROLLMENT

AGENT APPLYING ON BEHALF OF CLIENT

A. Pre-Enrollment

1. Do you want an ElderBridge SoCal Partner to drive client to appointments? Yes No N/A

2. Is client able to board and ride in a regular passenger vehicle independently or with minimal assistance? Yes No N/A

3. Is client willing and able to follow safety instructions, including using a seatbelt while in the vehicle? Yes No N/A

4. Is client willing to allow an ElderBridge Partner to accompany him/her into the exam room of the healthcare office to act as a patient advocate and report to the support team? Yes No N/A

5. Are you or is client willing to sign permission for ElderBridge Partner to access health records and talk to healthcare staff and doctors? Yes No N/A

B. Enrollment ($85 enrollment fee payable now) Service fee will be an amount agreed upon, between $28-$45/hour, payable with monthly invoice.

Client Name: ____ Date of Birth: ____________________

Residence Address: ____

Mailing Address (if different than residence): ____

Phone Number(s): ____________________________________ Email Address: _________________________________

C. Contact Information of Agent Completing Form

Name: ____ Relationship: ___________________________

Address:____

Phone Number: __________________________________ Email Address: _______________________________________

Do you have Power of Attorney for health care decisions for this client? Yes No N/A

Do you have Power of Attorney for financial decisions for this client? Yes No N/A

Who will be responsible for paying for ElderBridge SoCal services? ____

EMERGENCY CONTACT (if someone other than Agent): ____

D. Requested ElderBridge SoCal Services for Client (check all that apply or attach Assessment of Service Needs):

____ Spend time coaching independent living, optimal safety and whole-person health

____ Manage transportation to and from requested healthcare appointment(s)

____ Attend healthcare appointment(s): to ensure client talks about important symptoms, problems and questions; to hear and clarify answers, diagnoses and options for treatment; to understand in order to report to family/primary caregiver or client (patient advocacy)

____ Coach client or caregivers to successfully implement treatment plans

____ Evaluate effectiveness of care plan and advocate as needed for changes

____ Record current medications and supplements and provide printed document

____ Assist in filling pill organizer (circle one): Weekly Twice a month Monthly

____ Spend time at bedside or at side of client to understand the situation, advocate for best care and be communication liaison between client, family/primary caregiver and healthcare practitioners

____ Assist with transition to next level of care, according to decisions of client and/or agent designated as primary caregiver or Power of Attorney

____ Communicate as appropriate with health care team and/or designated support person(s)

____ OTHER NEEDS/REQUESTS: