Date:
How did you learn about ElderBridge SoCal?

ENROLLMENT
CLIENT

A. Pre-Enrollment

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

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

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

4. Are you willing to allow an ElderBridge Partner to accompany you into the exam room of the doctor's office to advocate on your behalf, then report back to your support team? Yes No N/A

5. Are you willing to sign permission for your 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 upon monthly invoice.

Your Name: _____ Date of Birth: _____

Residence Address: _____

Mailing Address (if different than residence): _____

Phone Number(s): _____ Email Address: _____

C. Emergency Contact(s)

Name/Relationship/Phone #/Email address:

D. Requesting ElderBridge SoCal Services (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: