Lifeline Systems, Inc.
111 Lawrence Street
Framingham, MA 01702

Lifeline Care Plan Agreement

☐ **This is a PARTIAL Install (Must complete all fields outlined in bold)**	☐ **This is a FOLLOW-UP Install; Number of pages included: 1 ☐ or 2 ☐**	Program Name	Program Phone Number

Program Code	Model Type	Unit #	Household Phone #	Installation Date/Time

Salutation	Subscriber Last Name	First Name	Middle	Suffix

Preferred Name	Last Name Sounds Like	Language Need?	Gender	Date Of Birth
		☐ Spanish ☐ Other_____	☐ Male ☐ Female	

Household Information			**Emergency Phone Numbers** (Do not list 911 or 800 #'s)		
Residential Street Address/Apt.#				Dispatch	Status
			POLICE		
City	State	Zip Code	**FIRE**		
Township/Municipality	County		**AMBULANCE**		

Household Hidden Key Location	**Directions To Home** (Must Be Provided If PO Box Listed)	**Additional Services**
		☐ Inactivity Alarm Service
		Special Instructions
		☐ State Funded ☐ Lifeline Smoke Detector

Drug Allergies	**Medical Conditions and/or Diseases**		**Household Warning**

Responder One	**Responder Two**	**Responder Three**
Name (First/Last)	Name (First/Last)	Name (First/Last)
Language Need? ☐ Spanish ☐ Other_____	Language Need? ☐ Spanish ☐ Other_____	Language Need? ☐ Spanish ☐ Other_____
Street Address	Street Address	Street Address
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Family Relation ☐ Have Key ☐ Family Caregiver ☐ Notify ☐ Reminder Contact	Family Relation ☐ Have Key ☐ Family Caregiver ☐ Notify ☐ Reminder Contact	Family Relation ☐ Have Key ☐ Family Caregiver ☐ Notify ☐ Reminder Contact
Phone ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell
Phone ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell
Phone ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell

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Program Code	Subscriber Last Name	First Name	Household Phone #	Program Name

Notify		**Notify**	
Name (First/Last)	Family Relation ☐ Family Caregiver ☐ Reminder Contact	Name (First/Last)	Family Relation ☐ Family Caregiver ☐ Reminder Contact
Phone ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell	**Phone** ☐ Home ☐ Work ☐ Cell

Primary Physician	**Third Party Notify**	
Name (First/Last)	Name (First/Last)	Fax Number
Phone	Name (First/Last)	Fax Number

Preferred Hospital		**Referral Source**	
Hospital Name		Name (First/Last)	**Phone**
City, State	**Phone** (REQUIRED)	Organization/Agency Name	Position/Title
☐ **Multiple Subscriber Household** ***(You must complete a separate Care Plan Agreement for each Subscriber)*** Name of Additional Subscriber		Street Address	City, State, Zip Code
		Coupon Code _____ – _____ Referral Source Code / Promotion Code	

Subscriber Notes

Payer Information

First Name/Organization Name	Last Name	Home Phone #
		Work Phone #
Billing Address		Cellular Phone #

City	State	Zip Code	Social Security Number	Medicaid Number

Billing Amount $	Shipping and Handling Fee $	Name on Credit Card		
☐ Monthly ☐ Quarterly ☐ Yearly	Enrollment Payment Method ☐ Invoice ☐ Credit Card	Ongoing Payment Method ☐ Invoice ☐ Credit Card	Credit Card Type ☐ Visa ☐ Master Card	Credit Card Number	Expiration Date

For Program Use Only (Not to be Entered by Data Entry)

Signature Of Subscriber	Date	Signature Of Payer (If Different)	Date

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