

Retired Senior Volunteer Program



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RSVP is funded by the Corporation for National & Community Service and
Suffolk County Office For the Aging

OFFICE: _____ Smithtown _____ East Hampton

TELEPHONE REASSURANCE

Client Enrollment Form

Date of Initial Call: _____ Enrollment Date: _____ Start Date: _____

Client's Name: _____ Phone: _____ M _____ F _____

Address: _____ Town: _____ Zip: _____ Cross Street: _____

Date of Birth: _____ Current Age: _____ Marital Status: M _____ W _____ D _____ S _____

Referred By: _____ Phone: _____ Relationship: _____

Lives Alone: ___ Disabled: ___ Frail: ___ Caucasian: ___ Black: ___ Hispanic: ___ Asian: ___ Native Am./Alaskan Nat. ___

What Language Does Client Speak: English: _____ Other (Please Specify) _____

Aide's Name: _____ Aide's Phone: _____ Agency Name & Phone: _____

Physician's Name: _____ Physician's Phone: _____

Special Health Conditions: _____

Living Arrangements: _____ Type of Residence: _____

Special Needs: _____

Does the client want information about any of the SCOFA Entitlement Programs (Medicare, Medicaid, SSI, HEAP, EPIC, Weatherization)? Yes _____ No _____

Other Relevant Information: _____

Emergency Contact Information (One contact is required to be enrolled.)

1. Relative Name: _____ Phone: _____ Relationship: _____

Address: _____

Are they aware of client's enrollment in Telephone Reassurance? Yes: _____ No: _____

2. Other Contact: _____ Phone: _____ Relationship: _____

Address: _____

Are they aware of client's enrollment in Telephone Reassurance? Yes: _____ No: _____

Call To Be Made: Daily: _____ Mon. _____ Tues. _____ Wed. _____ Th. _____ Fri. _____

8:30 am _____ 10 am _____ 11 am _____

(Rev. April 2021)