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 LIFELINE OF NEGMC	Program Phone Number 770-219-8899

Program Code	Model Type	Unit #	Household Phone #	Installation Date
GA037			( )	

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.#			**CENTRAL DISPATCH** ( )
			POLICE ( )
City	State	Zip Code	**FIRE** ( )
Township/Municipality	County		**AMBULANCE** ☐ **Check if Private** ( ) **ALTERNATE AMBULANCE** ( )

Household Hidden Key Location	**Directions To Home** (Must Be Provided If PO Box Listed)	**Additional Services**
		☐ Healthcare Directives ☐ 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
GA037			( )	LIFELINE OF NEGMC

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 *(If applicable organization name)*		Last Name		Home Phone # ( )
Street Address				Work phone # ( )
City	State	Zip Code	Social Security Number XXXXXXXXXXXXXXX	Medicaid Number

Monthly Fee(s)	One Time Fee(s)	Payment Frequency	Payment Method
Monitoring Service $XXXX Inactivity Service $XXXX $	Enrollment Fee $No Charge $XXXX Shipping & Handling	X Monthly ☐ Quarterly ☐ Yearly	X Invoice ☐ Credit Card ☐ Debit Card

Card Type	Name (as it appears on Card)	Card Number	Expiration Date
X☐ Visa X☐ Master Card X☐ American Express X☐ Discover	XXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXX

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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