Central Mississippi Planning and Development District
1170 Lakeland Drive Jackson, MS 39296-4935
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CMPDD PROMOTING REGIONAL EXCELLENCE SINCE 1968

REASSURANCE PROGRAM

Name:			Date:
Preferred Name:		Date of Birth:	Age:
Address:			Marital Status:
State/Province:	Zip/Postal Code:	Email:	
Home Phone:	Cell Phone:	Preferred Phone: ◯ Home ◯ Cell	
Phone location in Home:		Medication Reminder: ◯ Yes ◯ No	
If applicable, list mobile park or apartment complex name: Address: Name of Manager:			
Living Arrangement: (i.e. lives alone, with family, etc.)			
Primary Language:	Gender:	Ethnicity:	Health Plan:
Type of Call: ◯ Social ◯ Safety Check		Social Call: a daily friendly call with **NO** emergency Safety Check: a daily friendly call **WITH** emergency	
Time to Call:		Must be between 8:00 a.m. and 4:30 p.m.	
Name of Primary doctor:		Doctor's Phone Number:	
Preferred Hospital:		Hospital Number:	
Do you have a personal emergency response pendant?		If yes, which hospital or agency?	

What are some of your interest that you would like to talk about?

Emergency Contacts

Name:		Name:	
Address:		Address:	
Primary Phone:	Secondary Phone:	Primary Phone:	Secondary Phone:
Relationship?		Relationship?	
Does this person have a key to your home?		Does this person have a key to your home?	

PLEASE COMPLETE NEXT PAGE

How were you referred to the Telephone Reassurance Program? Please provide the name, address and phone number of the referral source:	
Telephone Reassurance Calls • Would you prefer calls daily? ______________ 2-3 times a week? ______________ 2-4 times a week?	
• Call are available between 8:00 a.m. to 2:00 p.m. daily. • What is your time preference for calls? ____	
What other agencies are providing you with services? (I.e. Meals on Wheels, Home Based Community Waiver, etc.)	
1)	
2)	
3)	
❖ In requesting services from the Telephone Reassurance Program, I understand that a confidential file will be kept including this application and other written notes regarding my history, health and designated resource specialist, and will not be released without my consent. These services are voluntary and I may cancel at any time. There is no cost for any services that the program provides.	
Signature:	Date:

PLEASE COMPLETE NEXT PAGE

Release of Information

PARTICIPANT NAME: ____

ADDRESS: ____

TELEPHONE: ____

DATE OF BIRTH: ____

In an effort to meet the needs of participants, it is sometimes necessary to contact and share information with other community services and agencies. This may include the disclosure of personal or confidential information. Sharing this information is intended to assist participants of the program.

☐ I authorize The Telephone Reassurance Program to obtain and/or disclose confidential information to/ from other community social services agencies.

_____________________________________ ______________

Participant Signature Date

Or __________________________________ ______________

Legal Representative Relationship

PLEASE COMPLETE NEXT PAGE

REASSURANCE PROGRAM

Welfare and Safety Check

In the event that we are not able to reach you by telephone after 48 hours, we may then contact local law enforcement and ask them to initiate a welfare and safety check. We will only take this course of action if we have not been able to reach available emergency contact numbers listed on your application. This means that the police will arrive to your home to make certain that you have not had an emergency.

Some participants do not wish us to notify the police under any circumstances. Please check below if this is your preference.

☐ If you cannot reach me by phone or my contacts, and I have not called to say I would be away, please **do not** initiate a welfare and safety check.

- ❖ **Central Mississippi Planning and Development District will not be held liable for your safety and welfare.**

NAME: ____

(Please print)

SIGNATURE: ____ DATE: ____________