Safe At Home

Participant Application

Please complete and return to Sheryl Watts:
sherylwatts@communityhealthstrategies.com
www.communityhealthstrategies.com

How did you hear about Safe at Home? _____

PARTICIPANT INFORMATION

Name: _____ Self-Direction Plan? Yes ☐ No ☐

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

CURRENT LIVING ARRANGEMENT

What type of housing does participant live in? House ☐ Apartment ☐ Certified Setting ☐

Other ☐ (please describe): _____

How long has participant lived in current home? _____

Does participant live with family members? Yes ☐ No ☐

Does participant live with roommates? Yes ☐ No ☐ How many? _____

Does participant have staff who assist in the home? Yes ☐ No ☐

If yes, how many hours per week is staff in the home? _____

CIRCLE OF SUPPORT

Support Staff Name: _____ Phone: _____

Support Staff Email: _____

Fiscal Intermediary Name: _____ Phone: _____

FI Email: _____

Family Member: _____ Phone: _____

Email: _____

Who is the best person to contact about this application? _____

PAYMENT AGREEMENT

Payment is due within 30 days of the final Safe at Home session.

Name of person responsible for payment: _____

Phone: _____ Email: _____

SIGNATURE: _____ DATE: _____