Home Care Call Application

INSTRUCTIONS: Applicant and Primary Care Giver must complete and sign this application. This form **MUST** be completed in full and returned to the address below. Should there be additional questions, the applicant or their representative should contact the Webster Parish Sheriff's Office / 911.
NOTE: Failure to complete this form may cause a delay in the processing of your application.

MAIL TO: Webster Parish Sheriff's Office / 911
Attention: Dal Taylor
P.O. Box 1101
Minden, LA 71058

DELIVER TO: Webster Parish Sheriff's Office / 911
410 Main St
Minden, LA 71055
TELEPHONE: (318) 377-1515

APPLICANT (Required)

Name:_____ **Home Phone**: (318)_____

Address:_____

Apt. No.:_____ **City**:_____ **State**: LA

Call Time Preference: ☐ Morning (9:30AM – 11:30AM) ☐ Afternoon (1:30PM – 3:30PM)

Standing Appointments:_____

_____

Physical Impairments:_____

_____

Dangerous Pets? ☐ Yes ☐ No **Able to Walk?** ☐ Yes ☐ No **Able to Drive?** ☐ Yes ☐ No

PRIMARY CARE GIVER (Required)

Name:_____ **Home Phone**: (318)_____

Address:_____ **Office Phone**:_____

City:_____ **State**: LA **Cell Phone**:_____

Main Contact Number:_____

Pager/Alternate Contact Information:_____

KEYHOLDER (Optional)

Name:_____ **Home Phone**: (318)_____

Address:_____ **Office Phone**:_____

City:_____ **State**: LA **Cell Phone**:_____

Main Contact Number:_____

Pager/Alternate Contact Information:_____

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CONFIDENTIAL - All information contained in this document is considered confidential. Rules of Confidentiality should be observed at all times.

CRITERIA FOR THE COMMUNITY ASSISTANCE RESPONSE SYSTEM

- Must be at least sixty-five (65) years of age and live alone.
- If younger than sixty-five (65) years of age, the person must have a serious illness such as diabetes, heart disease, seizures, etc. A doctor's statement should accompany this application.
- The applicant must live alone.
- A working telephone is required.
- The applicant must be able to speak the word "Hello". This can possibly be done by a recorded message, if necessary.
- The applicant must be able to press a button on their phone in response to a recorded voice announcement when called.
- The applicant must have at least one contact person.
- The applicant and the contact person must understand the guidelines that are provided and signatures are required.

In the event it is necessary that a Webster Parish Sheriff's Deputy be dispatched to the applicant's place of residence, the applicant, by signature below,

☐ **AUTHORIZES** a forced entry when necessary

☐ **DOES NOT AUTHORIZE** a forced entry unless visual evidence of an emergency condition exists.

By signing below, the "Home Care Call" ***Applicant*** and ***Primary Care Giver*** give Webster Parish 911 permission to place calls daily to the listed phone numbers by electronic devices and hold harmless Webster Parish 911 and the Webster Parish Sheriff's Office for any failed call attempts or omissions. Webster Parish 911 and Webster Parish Sheriff's Office will make every possible effort to confirm the wellbeing of said ***Applicant*** when requested by the notification system. The ***Applicant*** also agrees to notify Webster Parish 911 or the Webster Parish Sheriff's Office when calls are no longer needed so ***Applicant*** can be removed from the system. ***Applicant*** also acknowledges that calls will be made daily, during the mid-morning and mid-afternoon hours. The ***Applicant*** and the ***Primary Care Giver*** also acknowledge that calls to the ***Applicant*** or ***Primary Care Giver*** that are not answered or acknowledged will result in the dispatch of a Webster Parish Sheriff's Deputy to the home of the ***Applicant*** to check on the wellbeing of the ***Applicant***.

SIGNED BY:

Home Care Call Applicant:_____**Date**:_____

Primary Care Giver:_____

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