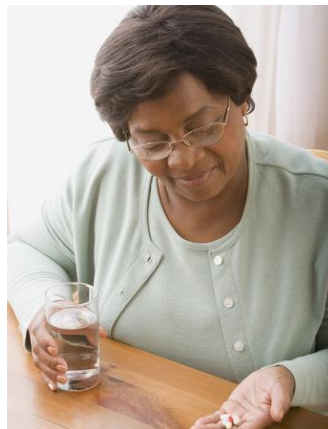




## DELAWARE COUNTY OFFICE OF SERVICES FOR THE AGING



## Domiciliary Care Program

### Consumer Application

RETURN COMPLETED APPLICATION TO:

Delaware County Office of Services for the Aging  
1510 Chester Pike, Suite 250  
Eddystone, PA 19022  
610-490-1300  
610-490-1500 (Fax)



## Consumer Application

Date: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Landline: \_\_\_\_\_

Email: \_\_\_\_\_

Sex: \_\_\_\_\_

Identified Gender: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Marital Status: \_\_\_\_\_

### **Monthly Income**

Social Security: \$ \_\_\_\_\_ SSI: \$ \_\_\_\_\_ Employment: \$ \_\_\_\_\_

Other Type: \$ \_\_\_\_\_

### **Bank Account Information**

Checking: \_\_\_\_ Yes \_\_\_\_ No

Saving: \_\_\_\_ Yes \_\_\_\_ No

### **Life Insurance**

\_\_\_\_ Yes \_\_\_\_ No

# Consumer Application

## **Contacts**

### **Family or Friend**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_ Email: \_\_\_\_\_

### **Physician**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Referral Source**

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

## **Diagnosis(es)**

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## **Help Needed With Daily Activities**

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## **Background Check**

Consumer agrees to criminal and child abuse background checks as part of application process.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Return Application**

### **MAIL**

Housing Director  
Delaware County Office of Services for the Aging  
1510 Chester Pike, Suite 250  
Eddystone, PA 19022

### **FAX**

Attention Housing Director  
610-490-1300

### **EMAIL**

**Subject: Dom Care Application**  
COSA@co.delaware.pa.us