

Shoreline Helping Hands

Service of VNA Community Healthcare, on the central CT shoreline

ENROLLMENT FORM

SUBSCRIBER INFORMATION

Name (Please print clearly):

Date of birth:

Phone: ()

Street address:

Bldg/Apt/Unit:

City:

State:

ZIP Code:

Own Rent (Please circle)

Email:

SPOUSE INFORMATION IF JOINT ENROLLMENT

Name:

Year of Birth:

Email:

SUBSCRIBER ___ OR SPOUSE ___ WORK CONTACT (check if applicable)

Name of Company:

N/A:

Participant or Spouse Phone: ()

INFORMATION IF ENROLLMENT PURCHASED AS A GIFT

Name (first, last) of person purchasing gift:

Relationship to Subscriber(s):

Daytime Phone:

SUBSCRIPTION FEE

First Year Fee (per household): \$99

(Check payable to: "Shoreline Helping Hands")

SIGNATURE

YES, I want to enroll with **Shoreline Helping Hands**, VNA Community Healthcare's referral source to trusted home and personal services. I understand that this service is for my use, that of my spouse living with me, or a family member on my behalf. I will not share my subscriber number with others.

Participant hereby releases **Shoreline Helping Hands** and its employees and holds them harmless for any claim for injury, damage or cause for an incident which may occur in relation to work performed by referred businesses.

Signature of applicant:

Date:

FOR OFFICE USE

Date Application Received:

10/06

Date Enrollment Activated (first of a month):

Participant #:

Check Enclosed:

Amount:

Mailing Address: VNA Community Healthcare, 753 Boston Post Road, Guilford, CT 06437

Credit Card: VISA ___ Mastercard ___ American Express ___ | Verbal Auth?

Credit Card Number:

Expiration Date:

Cardholder Name:

3-Digit Authorization Code:

Toll Free 866-474-5230

info@shorelinehelpinghands.com