



## ASPIRUS LIFELINE

333 Pine Ridge Blvd., Wausau, WI 54401  
715-847-2781 phone • 715-847-2015 fax

### Medical Alert Service Application

Subscriber's Last Name		First Name		Middle Name	Language Needs?
Household Phone Number (landline)		Cell Phone Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Does someone else live in the household? <input type="checkbox"/> No <input type="checkbox"/> Yes Name/Relationship: _____					
Complete Address/Apt. #		<b>Type of Service</b> - Please check one <input type="checkbox"/> Home Safe standard service (landline required) - <b>\$25 per month</b> <input type="checkbox"/> Home Safe standard service, with <b>Auto Alert</b> fall detection button (landline required) - <b>\$38 per month</b> <input type="checkbox"/> Home Safe wireless service for those without a landline - <b>\$41 per month</b> <input type="checkbox"/> Home Safe wireless service with <b>Auto Alert</b> for those without a landline - <b>\$56 per month</b> <input type="checkbox"/> GoSafe2 Mobile Medical Alert Service - \$45 per month and a one time \$99 pendant fee			
City/State/Zip Code					
Township/Municipality	County				
Household Hidden Key Location for Emergency Services			Directions to Home (and description of home)		
Drug Allergies		Medical Conditions and/or Diseases		Household Warning, Pets	
<b>List the 3 most available and closest persons. Should they not be available, we will engage the assistance of Emergency Services.</b>					
<b>Responder One</b>		<b>Responder Two</b>		<b>Responder Three</b>	
Name (First/Last)		Name (First/Last)		Name (First/Last)	
Street Address		Street Address		Street Address	
City/State/Zip Code		City/State/Zip Code		City/State/Zip Code	
Relationship <input type="checkbox"/> Have Key <input type="checkbox"/> Notify of incident		Relationship <input type="checkbox"/> Have Key <input type="checkbox"/> Notify of incident		Relationship <input type="checkbox"/> Have Key <input type="checkbox"/> Notify of incident	
Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	

Primary Physician		Preferred Hospital	
Name (First/Last)		Hospital Name	
Fax Number	Phone Number	City/State	Phone Number
Your physician will receive a fax notification regarding your installation of Lifeline equipment. <input type="checkbox"/> Check here If you do not want your physician notified.			
Third Party Notification of Incident by Fax (ex., Home Health, Physician, Agency)			
Name		Fax Number	

- Would you prefer to wear your waterproof Personal Help Button on a ☐ Nylon neck cord, as a necklace  
OR ☐ Wristband
- Auto Alert (Automatic Fall Detection) Personal Help button and the GoSafe2 Mobile button are only available on the neckcord.

What days and times of the week are convenient for installation? \_\_\_\_\_

Who is to be notified for installation date and time? (if different than subscriber) \_\_\_\_\_

Phone \_\_\_\_\_

**Which type of service do you wish to use?**

☐ **\$35 installation fee** must accompany application. Check payable to Aspirus Lifeline.

**Electronic Fund Transfer** is only option for Lifeline payment. See attached form (page 2).

☐ **\$25 month** Home Safe standard service (landline required).

☐ **\$38 month** Home Safe standard service with **Auto Alert** fall detection button (landline required).

☐ **\$41 month** Home Safe wireless service for those without a landline.

☐ **\$56 month** Home Safe wireless service with **Auto Alert** for those without a landline.

☐ **\$45 month** GoSafe2 Mobile Medical Alert service. The \$99 pendant fee must accompany application.

**Payer Information**

Name (First/Last or, if applicable, organization name) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Signature of payor (if different than subscriber) \_\_\_\_\_

**Tax is included in Lifeline pricing**

Aspirus Lifeline uses and discloses protected health information to provide, coordinate, and manage Personal Emergency Response services. All equipment is the property of Aspirus Wausau Hospital and must be returned in good, clean condition to Aspirus Wausau Hospital Lifeline. Service will be deactivated when equipment is returned.

**Signature of Subscriber (or person completing application)**

**Date**

Additional charges: Lost Personal Help Button fee - \$95; Lost Auto Alert Fall Detection Button fee - \$150

**Visit us online at [www.aspirus.org/lifeline](http://www.aspirus.org/lifeline)**

**Referral Source**

Name \_\_\_\_\_ Organization \_\_\_\_\_

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

# ELECTRONIC FUND TRANSFER PAYMENT AUTHORIZATION

## FOR LIFELINE PROGRAM (Recurring Payments)

Subscriber name: \_\_\_\_\_

I (we) hereby authorize Aspirus Wausau Hospital, Inc., hereafter referred to as Life Line, to initiate debit entries to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit the same to such account.

This authorization is for the purpose of paying for Lifeline Program billings and I understand that the amounts may vary and authorize payments in amounts as indicated below:

\_\_\_\_\_  
(Financial Institution Name)

**\$35 Installation Fee must accompany application. Make check payable to Aspirus Lifeline.**

\_\_\_\_\_  
(Address) (City/State) (Zip)

Routing Number \_\_\_\_\_ (9 digit)

☐ **Checking**

**OR**

☐ **Savings**

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Account Number

The Authority you give to change your account will remain in effect until you notify us in writing to terminate the authorization. If the amount of your payment changes, we will notify you at least 10 days before payment date. The Direct Payment Plan is dependable, flexible, convenient, and easy.

\_\_\_\_\_  
(Print account holder's name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

### **IF USING CHECKING ACCOUNT PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM!**

- All written debit authorizations must provide that the Receiver may revoke the authorization only by notifying the Originator in the manner specified in the authorization.
- Reversals do not require authorization by the Receiver. This would be for the purpose of correction of errors or refunding any credit balance on account.
- The underlined language in the authorization above represents the disclosure requirement associated with the clarification of OFAC economic sanction policies upon ACH Network Participants.