WE WHO CARE APPLICATION FORM

Member documents consist of the following documents that will be scanned and stored on your personal CD-Rom and our web site for immediate access by your health care providers:

1. Member Information
2. Living Will
3. Power of Attorney
4. Medical History
5. Contact List
6. Other - You may include additional documents to be stored.
   Do not include social security or account numbers.
7. Photo(s) for identification
8. Hospital Directory Authorization

Member Type: ☐ Single (Fill out First section) ☐ Spouse / Partner (Fill out First section AND Second section)

PRIMARY Member Information:

First: ______ Middle: ______ Last: ______

DOB: ______ Mother's Maiden Name: ______

Address 1: ______

Address 2: ______

City: ______ State: ______ Zip: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

E-Mail Address: ______

Accepted and Approved: ______ Date ______ Signature of Member ______ Printed Name

SPOUSE / PARTNER Member Information:

First: ______ Middle: ______ Last: ______

DOB: ______ Mother's Maiden Name: ______

Address 1: ______

Address 2: ______

City: ______ State: ______ Zip: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

E-Mail Address: ______

Accepted and Approved: ______ Date ______ Signature of Spouse/Partner Member ______ Printed Name

WE WHO CARE

HOSPITAL DIRECTORY AUTHORIZATION

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(In Compliance with HIPAA Reg. § 45 CFR 164.508)

TO: ANY Hospital, Clinic or Health Care installation where I may be admitted as a patient

You are hereby authorized in the event that I am physically unable to give permission to have my name, condition and room number disclosed, to place such information on the hospital directory so that when individuals interested in me contact the hospital, such information can be disclosed to them.

This authorization is initiated at my request.

I understand that the information disclosed may be subject to re-disclosure by the individuals who obtain it and that such information would no longer be protected by the federal privacy regulations. (45 CFR 164.508(c)(2)(3))

This Authorization will expire upon my release from your Hospital, Clinic or Health care installation.

Date: ____________________ ____

Signature of Individual

____________________ ____

Date of Birth

Printed Name

WE WHO CARE

DOCUMENT SUMMARY and PAYMENT INFORMATION

Document Summary

(Check items that you have Included)

- [ ] Member Information (Application Form)
- [ ] Living Will
- [ ] Power of Attorney
- [ ] Medical History
- [ ] Contact List
- [ ] Photo(s)
- [ ] Hospital Directory Authorization
- [ ] Other ______________________________

Type of Payment:

- [ ] Check / Money Order

- [ ] Visa
- [ ] Mastercard
- [ ] Discover
- [ ] American Express
- [ ] Debit Card

Number on Card: ______________ Expiration Date (mm/yy): ______________

Name on Card: (as it appears on card) ______________ CSC / CVV2 (if known): ______________

(added security feature on some cards)

Billing Address:

First: ______________ Middle: ______________ Last: ______________

Address 1: ______________

Address 2: ______________

City: ______________ State: ______________ Zip: ______________

Shipping Address:

- [ ] Check here if your Shipping Address is the same as your Billing Address

First: ______________ Middle: ______________ Last: ______________

Address 1: ______________

Address 2: ______________

City: ______________ State: ______________ Zip: ______________

Accepted and Approved:

____
Signature of Member

____
Printed Name

WE WHO CARE **MEDICAL HISTORY**

Section 1 - Physician(s), Conditions, Allergies and Implanted Devices

Patient Information:

First: ______ Middle: ______ Last: ______

DOB: ______

Address 1: ______

Address 2: ______

City: ______ State: ______ Zip: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

E-Mail Address: ______

Physician Information:

Primary Physician: ______ Specialty: ______

Phone Number: ______

Additional Physician: ______ Specialty: ______

Phone Number: ______

Additional Physician: ______ Specialty: ______

Phone Number: ______

Please complete the information below only with conditions relevant to immediate emergency treatment

Known Conditions: 1. ______ 2. ______
3. ______ 4. ______

Drug Allergies: 1. ______ 2. ______
3. ______ 4. ______

Other Allergies: 1. ______ 2. ______
3. ______ 4. ______

Implanted Medical Devices:
Include manufacturer, model & serial Number

1. ______
2. ______
3. ______

WE WHO CARE

MEDICAL HISTORY

Section 2 - Medications, Surgeries, Family Illnesses and Insurance

Medications:
Include Daily Dosage

	Medication Name		Dosage
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	
8.		8.	
9.		9.	
10.		10.	

Previous Surgeries and Procedures:

Major Family Illnesses:

Insurance Name:

Phone:

Policy / Group #:

Additional Information:

WE WHO CARE

CONTACT LIST

Page ________ of ________

1.

First: ____ Middle: ____ Last: ____

Relationship: ____

Address 1: ____

Address 2: ____

City: ____ State: ____ Zip: ____

Home Phone: ____ Work Phone: ____ Cell Phone: ____

E-Mail Address: ____

2.

First: ____ Middle: ____ Last: ____

Relationship: ____

Address 1: ____

Address 2: ____

City: ____ State: ____ Zip: ____

Home Phone: ____ Work Phone: ____ Cell Phone: ____

E-Mail Address: ____

3.

First: ____ Middle: ____ Last: ____

Relationship: ____

Address 1: ____

Address 2: ____

City: ____ State: ____ Zip: ____

Home Phone: ____ Work Phone: ____ Cell Phone: ____

E-Mail Address: ____