

**SWARTZ CREEK AREA SENIOR CITIZENS, INC.**

**Membership Application and Health Form**

Please complete and return the following personal information for our records. The medical information is helpful in an emergency here or on a trip. A yearly donation of \$10.00 per person is requested, but is not a requirement for membership.

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

**Man's First Name:** \_\_\_\_\_

**Woman's First Name:** \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Address: \_\_\_\_\_ Apt # or PO # \_\_\_\_\_

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

Township or City: \_\_\_\_\_ School District: \_\_\_\_\_

**Man's Birthday:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Woman's Birthday:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Man's Physician:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Medical Problems/Allergies/Handicaps: \_\_\_\_\_

Medications/Special Diet: \_\_\_\_\_

**Woman's Physician:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Medical Problems/Allergies/Handicaps: \_\_\_\_\_

Medical Problems/Allergies/Handicaps: \_\_\_\_\_

**EMERGENCY CONTACTS**

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

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_

**OPTIONAL**

The information below is very helpful for monthly reports to funding sources: (For reports, if this section is not filled out, it will be assumed you are white with an income above moderate level.)

Race/Ethnicity: \_\_\_ White \_\_\_ Black \_\_\_ Hispanic \_\_\_ Asian/Pacific Islander \_\_\_ American Indian/Alaskan Native

Family Income	Extremely	Very	Low Income	Moderate Income
	Low Income	Low Income		
One Person	___\$11,700	___\$19,450	___\$23,340	___\$31,150
Two Person	___\$13,350	___\$22,250	___\$26,700	___\$35,600
Three Person	___\$15,000	___\$25,000	___\$30,000	___\$40,050

I understand the information provided above will be kept confidential, unless there is a medical emergency at which time it may be released to the attending physician. I also understand information provided will be used by the Center in tabulation of required funding reports to United Way, Valley Area Agency on Aging, Community Development, and any future funding sources.

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

Last Updated \_\_\_\_\_  
or Reviewed \_\_\_\_\_