VRI CARE PLAN FORM

Monitoring Service	Unit Type	Unit Number	Smoke Enrolled	Household Phone #	Installation Date/Time

Salutation	Subscriber Name Last	First Name	Middle Name	Suffix

Preferred Name	Last Name Sounds Like	Language Need? (Blank If English)	Gender	Date Of Birth
			☐ **Male** ☐ **Female**	

Residential Street Address / Apt #				Emergency Phone Numbers (Do Not Use 911)
			POLICE	
City	State/Province	Zip/Postal Code	FIRE	
Township	County		AMBULANCE	

HOUSEHOLD HIDDEN KEY LOCATION	**DIRECTIONS TO HOME** (MUST BE PROVIDED IF P.O. BOX LISTED)
☐ Live-ins	TIME ZONE: HONORS DST? ○ Yes ○ No

PLEASE LIST DRUG ALLERGIES	**PLEASE LIST MEDICAL CONDITIONS**

RESPONDER CONTACT INFORMATION

☐ Has Key **RESPONDER ONE** ☐ Notify	☐ Has Key **RESPONDER TWO** ☐ Notify	☐ Has Key **RESPONDER THREE** ☐ Notify
Name (First/Last) Relation:	Name (First/Last) Relation:	Name (First/Last) Relation:
☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other
☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other
☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other
Responder Note:	Responder Note:	Responder Note:

☐ Has Key **NOTIFY ONLY**		☐ Has Key **NOTIFY ONLY**	
Name (First/Last)	Relation	Name (First/Last)	Relation
☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other
Note:		Note:	

Primary Physician Name (First/Last)	Physician Phone	Preferred Hospital Name	Hospital Phone

MEMBER NOTES

Member's Signature

Signature Of Payer (If Different)