



**CITY OF CLEVELAND**  
Mayor Justin M. Bibb

## Cleveland Care Calls Application Form

Department of Aging  
75 Erieview Plaza, Floor 2  
Cleveland, Ohio 44114

*Applicant: Please submit completed application to the address above. For Questions call 216-664-6316*

What time (between 7 and 11 am) would you like to receive your call?			Circle the day(s) of the week you would like to receive your call: MON TUES WED THUR FRI		
PHONE NUMBER			Does your phone have an answering machine? YES NO		
LAST NAME			FIRST NAME		MIDDLE INITIAL
STREET ADDRESS			APT. BUILDING NAME		APARTMENT #
CITY <b>Cleveland</b>	STATE <b>Ohio</b>	ZIP	DATE OF BIRTH	PRIMARY LANGUAGE	
Does anyone else live with you? If so, who?					
List any physical impairments or medical conditions below:					
Do you have pets? YES NO		NUMBER	TYPE	KEPT IN HOUSE/APT?	
Please note any special needs that Cleveland care calls should know about					
<b>EMERGENCY CONTACT INFORMATION</b>					
I understand that the above person has registered with "Cleveland Care Calls" and is to be called daily to check on their wellbeing. In the event that the above person does not respond to the call, I will be notified to check on their welfare. I am also aware that as an Emergency Contact I assume a responsibility to respond to the participant's residence when needed. I further acknowledge that if no Emergency Contacts can be contacted or are able to respond, a City of Cleveland, Department of Public Safety, Emergency Unit may be dispatched and, if necessary, the participant's residence may be forcefully entered.					
<b>EMERGENCY CONTACT 1</b>			<b>EMERGENCY CONTACT 2</b>		
NAME		MI	NAME		MI
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP		HOME PHONE		HOME PHONE	
WORK PHONE		CELL PHONE		CELL PHONE	
EMERGENCY CONTACT SIGNATURE					

**KEY-HOLDERS (IF OTHER THAN EMERGENCY CONTACT)**

KEY HOLDER 1			KEY HOLDER 2		
NAME		MI	NAME		MI
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE NUMBERS			PHONE NUMBERS		

**Cleveland Care Calls Participation Agreement and Waiver**

I agree to participate in the City of Cleveland’s “Cleveland Care Calls” program. I understand that through this program I will receive a telephone call daily at approximately the same time. My responsibility is to answer the telephone and follow the directions given. If I am unable to answer the telephone for any reason the program will continue to make several attempts for up to one half hour. At the conclusion of the half hour, if there is still no response to the system, it will attempt to contact the person/persons that I have designated as emergency or key-holder contacts. These emergency or key-holder contacts will respond and may enter my residence to check on my wellbeing. If for any reason my designated contacts are not available or otherwise not able to enter my residence, the City of Cleveland may forcibly enter my residence to check on my status. I understand that the City of Cleveland does not guarantee immediate response and will dispatch safety forces upon availability. I understand that if in the course of checking on my wellbeing, it is necessary for the Safety personnel to forcibly enter my home I am responsible for any damages.

I acknowledge that the City of Cleveland is providing this program as a public service and for no compensation. I acknowledge and agree that the City of Cleveland may, in its sole discretion and without notice, terminate this service at any time. It is also acknowledged that the service may fail at any time due to technical problems, human error, or other factors with and/or outside of the City of Cleveland’s control.

In consideration of these factors, I waive, release comma and hold harmless the City of Cleveland from any and all claims arising from a failure comma for any reason comma to provide the services contemplated by this Participation Agreement and I further waive, release, and hold harmless the City of Cleveland from any and all claims for direct, incidental consequential, or punitive damages arising from any act or omission of the City of Cleveland in the administration and/or performance of this program, including but not limited to damage caused by forced entry into my residence to check on my safety and wellbeing.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

*This service is provided by City of Cleveland Departments of Aging and Public Safety*