



**GARFIELD
HEALTH CENTER**
仁濟社區醫療中心



Elderly Support Services Request Form

長者支援服務申請表

Please complete this form and email or mail it to us. Once we receive your request, please allow up to 7 business days for our team to review, assess, and respond.

請填妥此表格並透過電子郵件或郵寄方式提交給我們。

我們收到申請後，將在7個工作天內進行審核與評估，並回覆您。

Email to/電子郵件發至: community@garfieldhealthcenter.org

Mail to/郵寄至: Garfield Health Center, Attn: Outreach Team
19138 E Walnut Dr N, #201, Rowland Heights, CA 91748

1) First Name: 名	2) Last Name: 姓
3) Date of Birth: 出生日期	4) Phone Number: 電話
5) Address: 地址	
6) Living Situation: 居住情況	<input type="checkbox"/> I live alone 我獨居 <input type="checkbox"/> I live with family 我和家人同住
7) Family and Social Support 親友與社區支援	<input type="checkbox"/> I lack family support 我缺乏親友支援 <input type="checkbox"/> I lack social support 我缺乏社區支援
8) Requested Services 所需服務	<input type="checkbox"/> Daily Life Assistance 生活小幫手 <i>Examples: moving small furniture, cleaning and organization, phone check-ins</i> 例如: 搬運小型家具, 清理與整理, 電話問候 <input type="checkbox"/> Problem-Solving & Community Engagement 協助解決問題與建立社區連結 <i>Examples: solving everyday issues, introduce suitable activities, health education</i> 處理日常生活遇到的問題, 介紹您參加合適活動, 健康教育



**GARFIELD
HEALTH CENTER**
仁濟社區醫療中心



9) Please specify your needs or situations we should know about.

請具體說明您的需求或其他需要我們了解的情況：

10) Emergency Contact Name
緊急聯絡人姓名

11) Relationship
和您的關係

12) Phone Number
電話

By signing below, I confirm that the information provided is accurate to the best of my knowledge, and I authorize Garfield Health Center to contact me regarding services for the elderly individual named above.

本人簽名確認上述資訊屬實，並同意仁濟社區醫療中心就上述長者支援服務與我聯繫。

Signature
簽名

Date:
日期