



Please return form and payment to:
50 Directors Drive,
Greenville SC 29615

Enrollment Form

1 **Name:** _____
First Middle Last

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: (Required) _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Emergency Contact Name: _____ **Relationship:** _____

Contact's Main Phone: _____ Contact's Cell Phone: _____

2 **I am interested in:**

Membership (\$48 per year) (check all that apply below):

Wellness: Health Screenings Fitness Classes Support Groups Educational Seminars

Financial Security: Insurance Financial Planning Legal Services Consumer Protection

Lifestyle Activities: Group Travel Computer Classes Educational classes Art classes
 Volunteer opportunities Games Dance Music classes

Need based services (must qualify for these services)

Daily Meal Transportation Homecare

3 **Help us get to know you better**

Gender: Female Male **Ethnicity:** Caucasian Hispanic/Latino African American Other

I am: Single Married Widowed

I live:

Alone With friend/roommate With spouse With children With other family members

Other _____ # in household _____

I am: Retired Working Part-time Working Full-time a Caregiver of a spouse or parent

a Veteran, branch served: _____

Previous occupation: _____

Years lived in this area: New to the area 1 - 5 years 6 - 15 years All my life

I have the following chronic health conditions (check all that apply):

Diabetes High blood pressure Fibromyalgia COPD/lung condition Arthritis

Cognitive/memory impairment Hearing impairment Vision impairment

Primary Care Physician: _____ Office Name: _____

Please turn over and fill out the reverse side

Help us get to know you better (Continued)

How many children do you have (#), if any? _____; Grandchildren (#) _____

Name of son/daughter: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Name of son/daughter: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Name of son/daughter: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Do you have any pets? yes no

If yes, please tell us more: _____

Name of place of worship, if any: _____

What other civic groups are you a member of? _____

How did you hear about Senior Action?

Newspaper Website Presentation Physician Friend/Family

Name of person we can thank for the referral: _____

Are there programs and/or services that you would like to see Senior Action offer?

Do you have a special skill that you would like to share as a course instructor or a special presentation?

Senior Action likes to include photographs of our members enjoying life with each other in various publications. Please let us know if you *DO NOT* want Senior Action to use your picture in publications and promotional pieces.

Please **DO NOT** use my photograph in printed materials

Thank you for completing this form and we look forward to serving you for many years to come!

OFFICE USE ONLY

Spark rcv'd _____
 Card # _____
 DDR _____
 CC Cash Check # _____
Date Received: _____
Computer: _____

Prog Coor. _____
 HW Coor. _____
 Vol Coor. _____

