C.E.P. Program Application

Name:_____

Mailing Address:_____

Phone:_(____)_____

Email Address:_____

Primary Care Provider:_____

Location of Provider (name/city of hospital):_____

Next appointment you would like us to accompany you to
Date:_____
Time:_____
Address:_____

Which county do you reside?(check one):

- **Marion**
- **Polk**
- **Yamhill**
- **Lincoln**
- **Tillamook**

***Note**: **There is a $5.00 annual membership fee to enroll into this program**

~Checks are only accepted with printed applications
~Make check payable to: Aging with Support Inc.
~Please mail application and check to: 2 First Ave Grand Ronde OR 97347

FOR OFFICE USE ONLY

Check #:_____ Date received:_____ Amount:_____

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