Membership Application

At HOME on the Sound

PO Box 523 Mamaroneck, NY 10543

Date _____

Please Check One: ◯ Individual ◯ Household ◯ Associate Individual ◯ Associate Household

1st Member

Date of Birth_____

Name _____
Last First MI

Street Address_____

City_____ Zip _____

E-Mail Address_____

Home Phone # _____Cell Phone # _____

Local Emergency Contact _____Relationship_____

Address_____ ___City_____State _____Zip Code_____

Local Emergency Contact Home # _____ Cell #_____ E-Mail _____

2nd Emergency Contact _____Relationship_____ E-Mail _____

2nd Emergency Contact Home Phone # _____ Cell Phone # _____

Use Cane ◯ Use Walker ◯ Vision Impaired ◯ Hearing Impaired ◯ Have an Aide? Part-time ◯ Full-Time ◯

2nd Member (If Applicable)

Date of Birth_____

Name _____
Last First MI

E-Mail Address_____

Home Phone # _____Cell Phone # _____

Local Emergency Contact _____Relationship_____

Address_____ ___City_____State _____Zip Code_____

Local Emergency Contact Home # _____ Cell #_____ E-Mail _____

2nd Emergency Contact _____Relationship_____ E-Mail _____

2nd Emergency Contact Home Phone # _____ Cell Phone # _____

Use Cane ◯ Use Walker ◯ Vision Impaired ◯ Hearing Impaired ◯ Have an Aide? Part-time ◯ Full-Time ◯