APPLICANT NAME: _____ DATE: _____

East Baton Rouge Parish Council on Aging
Transportation Services Application

Applicant Information

Last Name: _____ First: _____ Middle: _____

DOB: _____ Last 4 of SS #: _____ Primary Contact #: _____

Mailing Address: _____ City: _____ Apartment #: _____

State: _____ Zip Code: _____ Apartment Name: _____

Physical Address (If different from mailing address): _____

City: _____ State: _____ Zip Code: _____

Apartment name/#: _____ N**OTE: Your physical address will be your pick up location.**

Primary Language: _____ Race: _____

What type of income do you receive? _____ How much is your monthly income? _____

Emergency Contacts

Name: _____ Relationship: _____

Street: _____ City: _____ State: _____

Zip Code: _____ Home Phone#: _____ Cell Phone #: _____

Name: _____ Relationship: _____

Street: _____ City: _____ State: _____

Zip Code: _____ Home Phone#: _____ Cell Phone #: _____

Medical Information

Primary Physician Information:

Name: _____ Agency: _____

Office Address: _____ City: _____ State: _____

Phone Number: _____ Fax Number: _____

APPLICANT NAME: _____ DATE: _____

Transportation Information

What Site Center do you attend? _____ Do you own a car? _____

How often do you visit the site center? _____

What type of transportation do you currently have? _____

Do you have a STAT card? _____ If yes, does it allow you to sign in at the site center? _____

If no, have you applied for it? _____

Do you require any accommodations or have any restrictions when traveling? _____

If yes, please explain. _____

_____

Have you been medically diagnosed with any disabilities? _____ If yes, list them all. _____

_____

Do you need assistance getting in and out of a vehicle? _____ Do you use any assistive devices? _____

Check all that apply:

Wheelchair ___ Electric Wheelchair ___ Powered Scooter ___ Cane ___ Walker ___ Crutches ___ Prosthesis ____

Rolling Walker ___ Manual Scooter ___ Portable Oxygen ___ Other _____

Service Animal ____ What service does your animal provide? _____

If you use a wheelchair or scooter, does your residence have a wheelchair ramp? Yes_____ No_____

If no, how do you transport your wheelchair to street level? _____

(Driver will not transport wheelchair up or down a step to or from your residence or any other facility in our service area.)

If necessary, can you transfer yourself from a wheelchair to a passenger seat? _____

Do you have a personal care assistant (PCA) that helps you get around? _____

If yes, what is your PCA's name? _____ Contact Number: _____

Disclaimer and Signature

I certify that the information I have given in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information is kept confidential and only the information required to provide the services I request will be disclosed to those who perform the services. .

Applicant Signature: _____ Date: _____

For Office Use Only

Date Received_____ STAT # _____ Eligibility Determined YES ___ NO ___ Date_____ Notice Sent _____