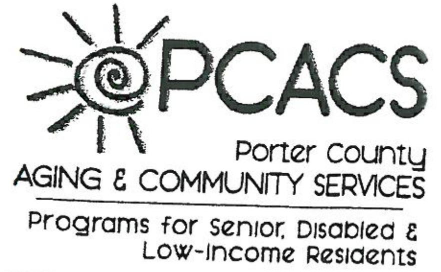
Transportation Client In-take form



Accessible formats available upon request

Last Name ______________________ First Name ______________________

Street Address ____________________________________ (ask if it's St, Ave, Dr, etc.)

City __________________________ Indiana Zip Code ____________

Township __________________ Telephone # (219) __________________

Date of Birth ________________(mm/dd/yyyy)

Medicaid # ______________________________________ (12 digits)

Is the client disabled.......................................☐Yes.........☐No

Does the client have a Spenddown?..........................☐Yes ....☐No

Is the client Ambulatory?...☐Yes......... ☐No

Does this client use a wheelchair?..............................☐Yes..........☐No

☐ Standard ☐ Electric ☐ Oversized

Is the client requesting financial assistance?..............☐Yes...........☐No

Does the client use a service animal?..........................☐Yes...........☐No

Does the client use a Personal Care Assistant?...........☐Yes............☐No

Emergency Contact

Name____

Relationship______________________ Phone____________________

Comments ____

____

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Form Completed By ______________________ Date ______________