Travelers Aid / Senior Ride Program – Enrollment Card

NAME:_____ **DATE:**_____

ADDRESS:_____**CITY:**_____ **ZIP:**_____

TELEPHONE:_____ **ADDRESS DESCRIPTION:**_____

EMERGENCY CONTACT:_____
(name, relationship and daytime phone number)

REFERRAL SOURCE (Company, Name & Phone #):_____

PRIMARY DESTINATION: (Clinic Name)_____

ADDRESS:_____ **M.D.**_____ **PHONE#**_____

PRIMARY HEALTH ISSUES:(Cancer, hypertension, diabetic, other) _____

_____

SPECIAL ACCOMMODATIONS: WC-Manual_____ **WC-Electric**_____ **Lift**_____ **Other**_____

IS THE PATIENT ABLE TO TRANSFER FROM WHEELCHAIR TO VEHICLE:_____

COMMENTS:_____

_____

_____

DOB:_____**AGE:**_____ **GENDER**_____ **ETHNICITY**_____

HOUSEHOLD MEMBERS:_____

HEALTH INSURANCE:_____

MONTHLY INCOME: SOC. SEC. (retirement):$_____ **SSD: $**\_\_\_\_\_**SSI:$**_____

TANF/CHILD SUPPORT:$**\_\_\_\_\_ **PENSION:$_____ **NONE/OTHER:$**\_\_\_\_\_ **V.A:$**_____

TOTAL MONTHLY INCOME: $_____

INCOME ADJUSTMENTS: Rent/Mortgage $_____ **Utilities $**_____ **Medications $**_____ **Other $**_____

ADJUSTED MONTHLY INCOME: $_____

HOW WAS TRANSPORTATION PREVIOUSLY MANAGED: _____

DOES ANYONE IN THE HOUSEHOLD HAVE A CAR? _____

OTHER INFORMATION: _____

_____

_____