Effective 8/17/2017

CLIENT REGISTRATION FORM
SECTION 5310-ELDERLY INDIVIDUALS AND INDIVIDUALS WITH DISABILITIES PROGRAM

1. NAME: Last: _____First: _____MI: _____

2. ADDRESS: _____

City: _____Zip: _____County:_____

3. Phone #: _____ **4.** Date of Birth: _____

5. Sex:
- ☐ Female
- ☐ Male

6. Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

7. Mobility Status:
- ☐ Ambulatory
- ☐ Uses a walker or cane
- ☐ Uses a wheelchair

8. Race:
- ☐ Black
- ☐ White
- ☐ American Indian
- ☐ Hispanic or Latino
- ☐ Other:_____

9. Type of Transportation needed: (check all that apply)
- ☐ Doctors Appointment ☐ Pharmacy Appointment
- ☐ Dialysis Appointment ☐ Adult Day Care
- ☐ Physical Therapy Appointments
- ☐ Other:_____
  Please Specify

10. If client is under the age of **65**, please provide proof of disability documentation.
The following are the types of documents that can be used as proof of disability:
- Statements or letters on a physician's/medical professional's letterhead stationary.
- Statements, records or letters from a Federal Government agency that issues or provides disability benefits.
- Statements, records or letters from a State Vocational Rehabilitation Agency counselor.
- Certification from a private Vocational Rehabilitation or other counselor that issues or provides disability benefits.

I, the client, understand that the information contained on this form will be kept confidential unless disclosure is required by court order or for authorized federal, state or local program reporting and monitoring. **I, the client, attest that I am currently not receiving health insurance through the Medicaid program.** My signature authorizes the providing agency to begin the service requested. (If collecting information by phone please note on line for client signature)

DATE:_____CLIENT SIGNATURE:_____

DATE:_____ AGENCY EMPLOYEE SIGNATURE:_____

EMERGENCY CONTACT PERSON: Name:_____
Phone (day):_____-_____-_____ (evening):_____-_____-_____
☐ Declined to provide emergency contact information