

REGISTRATION FORM

Date:		Number of Riders:	
Name:		Email Address:	
First	MI	Last	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			
City:		State:	Zip Code:
Apartment Complex Name:		Telephone:	Birthdate:
Cell Phone:		Smartphone <input type="checkbox"/> Yes <input type="checkbox"/> No Do you text? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last 4 digits of Social Security #:		Do you live in an Assisted Living or Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility:	
Do you attend a Senior Center? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Senior Center:			
Living Situation: <input type="checkbox"/> Homebound <input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives With Spouse <input type="checkbox"/> Lives with Others			
Medicaid Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No		Persons in Family	
Income Below National Poverty Level: <input type="checkbox"/> Yes <input type="checkbox"/> No		Poverty Guideline	
(This information is used for reporting purposes only and is confidential)		1	
		2	
		3	
		4	
Race: <input type="checkbox"/> African-American <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Information Unavailable			

MOBILITY INFORMATION

<input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheel Chair <input type="checkbox"/> Motorized Wheel Chair <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Assist dog <input type="checkbox"/> Needs Lift <input type="checkbox"/> Other		
Do you have a wheel chair ramp at your residence? <input type="checkbox"/> Yes <input type="checkbox"/> No	Escort Need: <input type="checkbox"/> Yes <input type="checkbox"/> No	Speaks Limited English: <input type="checkbox"/> Yes <input type="checkbox"/> No
Frail/Impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, specify):		
Special Pick Up Instructions:		
Special Needs:		

MEDICAL INFORMATION

Primary Physician:	Office Phone:	Emergency Phone:
Address:		
City:	State:	Zip:
Medical Conditions:		
Medications:		
Allergies:		

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Telephone:
		Alternate Telephone:
Address:		
City:	State:	Zip:
Name:	Relationship:	Telephone:
		Alternate Telephone:
Address:		
City:	State:	Zip:

MAIL TO:

Senior Transportation Connection
4735 West 150th St., Ste. A
Cleveland, OH 44135

FAX: 216-265-2830

Phone: 216-265-1489

Office Use Only

Date Registered _____

Registered by _____

Provider _____

Funder _____

Fare Type _____

Special Notes _____
