

For Office Use Only

Update/\_\_\_\_\_

WIA\_\_\_ SAMS\_\_\_ CARD\_\_\_ INTAKE\_\_\_ WHEELCHAIR: YES\_\_\_ NO\_\_\_

Form #1

**WAYNE COUNTY SENIOR CITIZEN'S MEMBERSHIP APPLICATION  
WAYNE COUNTY TRANSPORTATION - SHARED RIDE INTAKE SHEET**

DATE\_\_\_\_\_ DISTRICT:\_\_\_ - \_\_\_ - \_\_\_ ZONE:\_\_\_\_\_

NAME:\_\_\_\_\_ SS#\_\_\_\_\_ DOB\_\_\_\_\_ SEX:\_\_\_  
(Last) (First)

ADDRESS:\_\_\_\_\_ Street Address City State Zip Code

PHONE:\_\_\_\_\_ PROOF: YES\_\_\_ NO\_\_\_

PROOF TYPE: Birth Cert. Baptismal Cert. Dr. Lic. AF Disc. SSA VA PACE  
Nat. Resident/Alien Card Vet. Universal Access ID Card

EMERGENCY CONTACTS Permission to call ambulance in emergency. Y N  
(Ambulance phone #\_\_\_\_\_)

Name Relationship Address Phone

Name Relationship Address Phone

Physician's Name Address Phone

**CLIENT SIGNATURE #1** \_\_\_\_\_ Wayne County AAA

AGING/MATP/HSDP/COMP (Workmans' Comp)/INS (Accident)/Intake Sheet  
OTHER INTAKE INFORMATION: (For certain service other than 65+ and/or subsidy)

1. Cauc. 4. Hisp. (B) VETERAN Yes No  
2. Black 5. Amer. Ind.  
3. Hisp (W) 6. Asian 7. Other MARITAL STATUS: M W D SN SP

INCOME: Monthly Total\_\_\_\_\_ SOURCES: SSA SSI INT PENS. OTHER SSD DPA

ACCESS: 1 - 2 - 3 MEDICAL ASSISTANCE: Y\_\_\_ N\_\_\_ HSDP/ASBG: Y\_\_\_ N\_\_\_

LIVES WITH: 1 - 2 - 3 - 4 - 5 - 6 DWELL: HOM - HSE - APT - SNF - ICF

ADL: 1 - 2 - 3 - 4 - 5 DOM - PCH - EHU - GRH - OSC - CLA

Is the condition for which you are being transported the result of an accident? Yes No  
If yes, is it work-related? Yes No Car Accident? Yes No

**CLIENT SIGNATURE #2** \_\_\_\_\_ Wayne County AAA

(PLEASE TURN PAGE OVER TO COMPLETE FORM)

**CHECK ONE**

- 1. Are you wheelchair bound? Yes\_\_\_ No\_\_\_
- 2. Are you able to transfer on your own from wheelchair to vehicle or chair? Yes\_\_\_ No\_\_\_  
If no, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 3. Is your wheelchair: **Motorized** Yes\_\_\_ No\_\_\_ **Manual:** Yes\_\_\_ No\_\_\_
- 4. Is a ramp in place at your home on which you may wheel from your house to the Agency Van?  
Yes\_\_\_ No\_\_\_

**\*If you are wheelchair bound, you *must* have an escort.**

**DIRECTIONS & MAP:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CLIENT CONSENT FOR RELEASE OF INFORMATION**

I give my permission to a representative of the Wayne County Area Agency on Aging to contact appropriate Medical Facility(ies), Medical Personnel, and/or Social Service Agencies or other Community Service Agencies, concerning my need for Medical Services and other appointments and my need for Transportation thereof.

\_\_\_\_\_  
**Client's Signature**

\_\_\_\_\_  
**MA#/Exp. Date**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed (Signature)