

**WAYNE COUNTY TRANSPORTATION SYSTEM
MEMBERSHIP APPLICATION**

DATE _____ INTAKE UPDATE

NAME _____ SSN _____ Date of Birth _____ GENDER ____
(Last) (First)

RESIDENCE ADDRESS _____
Street Address City State Zip Code

MAILING ADDRESS _____

HOME PHONE _____ CELL _____

PROOF OF AGE (Check one, and attach a copy.)

- Driver's License Birth Certificate Baptismal Certificate Armed Forces Discharge
 PACE ID Card Nat. Resident/Alien Card Veteran's Universal Access ID Card
 Statement of Age from Social Security Administration

If you have a Medical Access card, check here and also attach a copy.

Medical Assistance Transportation Program Yes No

Veteran Yes No

HSBG Yes No

EMERGENCY CONTACTS

Name	Relationship	Address	Phone
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Name	Relationship	Address	Phone
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Physician's Name	Address	Phone
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I acknowledge that all of the above information is true and correct to the best of my knowledge, and I acknowledge that I have received a Welcome Brochure from the Wayne County Transportation System.

CLIENT SIGNATURE #1

Wayne County Staff Signature

Please turn page over to complete form.

MOBILITY AND DISABILITY INFORMATION

- 1. Will you be traveling with an assistant or escort? Yes No (If yes, the assistant or escort must complete a separate membership application form.)
- 2. Do you use a wheelchair or other mobility device? Yes No (If no, skip items 3-5)
- 3. Are you able to transfer on your own from the device to a vehicle or chair? Yes No
If no, please explain: _____

- 4. Is the mobility device: Motorized Yes No Manual Yes No
- 5. Is a ramp in place at your home on which you may wheel from your house to the Transportation vehicle? Yes No

DIRECTIONS (Attach map, if available.) _____

CLIENT CONSENT FOR APPOINTMENT VERIFICATION CONTACT

I give my permission to be contacted via phone by an automated interactive voice response system to confirm the scheduling of Transportation trips.

Preferred contact number Home phone Cell

CLIENT SIGNATURE #2

Wayne County Staff Signature

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 SIGNATURE #3

MA#/Exp. Date

Date

Witnessed (Signature)

For Office Use Only

Lottery AAA PwD MATP GP BH C&Y Exc HSBG ID PDA Waiver

Revised 09/2016