

**SENIOR TRANSPORTATION RIDERSHIP FORM**

Name \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
(Street) (Apt#)

Phone: (\_\_\_\_) \_\_\_\_\_ Township: \_\_\_\_\_

Gender: (\_\_\_\_) M (\_\_\_\_) F

Health Insurance Provider: \_\_\_\_\_

Would you require the platform lift to bring you up into the vehicle?  Yes  No

Do you use a wheelchair or motorized wheelchair?  Yes  No

Would you have an aide accompany you?  Yes  No

Does anyone living in your home drive?  Yes  No

Do you live by a Stars bus route?  Yes  No

Please check if you participate in either of these providers  P.A.C.E. Program  Medicaid Waiver

**Emergency Contact 1 :** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_ Alt. Phone: (\_\_\_\_) \_\_\_\_\_

**Emergency Contact 2 (If needed):** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_ Alt. Phone: (\_\_\_\_) \_\_\_\_\_

Will you use our transportation services for: Medical Appointments (\_\_\_\_) Yes Groceries: (\_\_\_\_) Yes

How often: Weekly (\_\_\_\_) Monthly (\_\_\_\_) Occasionally: (\_\_\_\_)

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_