

SILVER KEY TRANSPORTATION REGISTRATION

OFFICE USE ONLY

Date Entered

___/___/___

By: _____

Date: _____

Name: (Last) _____ (First) _____ (MI) _____

Age: _____ DOB: _____ SS#: _____ - _____ - _____ Gender: MALE FEMALE

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Name of Complex: _____ Phone: _____

Mailing Address (If different from above): _____

City: _____ State: _____ Zip: _____

Are you: Elderly Disabled Frail ADA Certified: YES NO Certification Number: _____

Disability: Cancer Kidney Failure Amputation Arthritis
 Brain Injury Dementia Seizure Disorder Multiple Sclerosis
 Parkinson's disease Stroke Hearing Impaired Vision Impaired
 Spinal Cord Injury Temporary Disability Mental Condition (PTSD, Autism, etc.)
 Heart Conditions Diabetes Alzheimer's Other: _____

Race: Caucasian Asian Hispanic African American Native American Hawaiian or Other

Are you a Veteran? Yes No What is your primary language? _____

Do you live alone? Yes No How many people live in your household? _____

If you live alone, is your individual income below \$982? Yes No

If you have a spouse or partner, is your monthly household income below \$1,329? Yes No

Medicaid: Yes No Medicaid HCBS: Yes No Medicaid #: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Silver Key Transportation Registration Cont'd.

Mobility Status

Space type: AMB Lift Wheelchair **WC Type:** Manual Powered Scooter

Mobility Aides: None Cane Crutches Oxygen Walker White Cane

Will you need additional assistance: (ex. Help with mobility aid, door through door service, or help up and down stairs?)

Yes No

Explain: _____

Will you have a Caregiver ride with you? Yes No Service animal? Yes No

Do you have vision problems? Yes No Do you wear eyeglasses? Yes No

Do you have hearing problems? Yes No Do you use a hearing aid? Yes No

Please note any serious medical conditions: _____

Referral Requested: Yes No Type: Care Mngt. Nutrition Health Equip Other

How did you hear about our services? _____

NOTES _____

OFFICE USE ONLY

Referred to Metro for
ADA Certification

YES: NO:

OFFICE USE ONLY

Funding Source

PPAAA: CITY: RTA: GENERAL:

Prepared by: _____

Date: _____