Concho Valley Transit District

5310 Elderly (65+) & Disabled Client Intake and Service Request Application

Client Rights & Responsibilities and Release of Information have been clearly explained to the client: Yes ☐

Veteran Verification: Are you a Dependent, Surviving Spouse, or Veteran? Yes ☐ **No** ☐

Date: _____ Client ID Number: _____

Last Name: _____ **MI**: _____ **First Name:** _____

Gender: **Male** ☐ **Female** ☐ **Birth Date:** _____ Primary Language: _____

Home Address: Street/Apt. #: _____

City: _____ **State**: _____ **Zip Code:** _____ **County**: _____

☐ **Check if Mailing Address is Home Address**

Mailing Address: Street/Apt. #: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: (_____) _____ Home ☐ Cell ☐ Other ☐ (Check One)

Living Environment

Does the client live alone? Yes ☐ **No** ☐

If no, what is the total number of Family Members in Household including Client: _____

Does the client have a Personal Care Attendant? Yes ☐ **No** ☐

Mobility Aids Used

Mark all that apply:

☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Power Scooter ☐ Long Wheelchair

☐ High Wheelchair ☐ Wide Wheelchair ☐ Stroller-Type Chair ☐ Walker (non-foldable)

☐ Walker (Foldable) ☐ Cane/White ☐ Crutches ☐ Braces

☐ Service Animal ☐ Prosthetics ☐ None of these

Please check which applies:

☐ Portable Oxygen ☐ Communication Device ☐ Other, please describe:_____

☐ None of these

If you use a manual or powered wheelchair or scooter, is it more than 30" wide, more than 48" long, or does it, when in use, weigh more than 600 pounds? Yes ____ No ____

Medical/Disabling Condition

List all conditions/disabilities that apply:

☐ Paraplegic ☐ Multiple Sclerosis ☐ Stroke ☐ Quadriplegic

☐ Diabetes ☐ Legally Blind ☐ Intellectual Disability ☐ Arthritis (hip, leg, other)

☐ Epilepsy ☐ Asthma ☐ Alzheimer's ☐ Other

If other, please explain:

_____

Please explain the severity/level/degree of disabling condition:

_____

_____

_____

Is this condition/disability temporary? Yes ___ No ___
If Yes, expected duration--until: _____

Is there any other medical information or effects of your disability that CVTD should know in the event of an emergency? (e.g. Hepatitis, Tuberculosis, Asthma)
Explain:_____

Emergency Contact Information

Contact Name: _____ Phone: (_____) _____

Relationship: _____

Service(s) Requested: _____

Are you enrolled in? ☐ ADA – ADA# _____ ☐ Medicaid – Medicaid # _____

Referred By:_____

For Administrative Use Only

Staff Completing Eligibility Assessment:_____
Client ID#:_____ Approved: Y / N Date Received:_____ Assessment Date:_____
Elderly: Y / N Disabled: Y / N