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: _____