

Last Name:		First Name:				M.I.	
Street Address:						Apt.	
City:			Zip:		E-Mail		
Primary Phone:()				Alt Phone:()			
Date of Birth:			Gender: Male Female				
Medicaid Recipient: Yes No			Medicaid Number:				
Race / Ethnicity		Check		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
all that apply		White	Black	Hispanic	Asian/Pac Is.	Amer. Ind.	Other
Disability							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Impaired	Cognitive Impaired	Develop. Disabled	Hearing Impaired	Mentally Impaired	Physically Impaired	Speech Impaired	Seizures
Visually Impaired							
Emergency Contact:				Emergency Contact Phone: ()			
Can Passenger be left home unattended?				Yes No			
Mobility Aides Used:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		None	Walker	Lift Required	Wheelchair		
Assistance Needed To/From Vehicle		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		None	Seasonal	Door to Door	Door through Door	Person to Person	
Special Considerations:							
Agency Registering Passenger							
Agency Name:							
Printed Name of person completing form:							
Signature of person completing form:							
Authorized by:							
Contact Number:				Date Form Completed:			
Customer Care Center Use Only							
Registration Completed by:							
Date Completed:				Confirmation Provided To:			