VOLUNTARY ACTION CENTER

TRANSPORTATION SERVICE REGISTRATION FORM

1606 BETHANY RD, SYCAMORE, IL 60178
PHONE (815) 758-3932 FAX (815) 758-0202

REQUESTED SERVICE(S): TRANSVAC ___ MEDVAC ___

Please Print Clearly and Fill in all Blanks

TODAY'S DATE _____

NAME: _____
(First) (Middle) (Last)

ADDRESS: _____
(Street name and number) (Apt #) (City) (Zip Code) (Township)

PHONE: _____ BIRTH DATE _____

SEX: Male _____ Female _____
RACE:
____ American Indian/Alaskan Native
____ Asian/Pacific Islander
____ Black, African American
____ Hispanic
____ White, Not of Hispanic Origin

NUMBER IN HOUSEHOLD: _____
LOW INCOME: Yes _____ No _____

ETHNICITY: _____ Not Hispanic or Latino
_____ Hispanic or Latino

DO YOU HAVE A MEDICAID MEDI-PLAN CARD? YES ____ NO
NAME (Exactly as it appears on the Medi-Plan Card) _____
MEDI-PLAN RECIPIENT NUMBER FROM BACK OF CARD (ID #)_____

DO YOU HAVE A DISABILITY? YES ____ NO ____

If Yes, Please Describe:

DO YOU USE: ____ Wheelchair ____ Cane ____ Service Animal
____ Motorized Scooter ____ Walker ____ Crutches
____ Portable O2

DO YOU HAVE A VISUAL ____ OR HEARING ____ IMPAIRMENT?

DO YOU NEED ASSISTANCE WITH USING OUR TRANSPORTATION SERVICE: ___ Y ___ N

If Yes, Please Describe: _____

DO YOU HAVE AN ILLNESS OR ANY OTHER CONDITION THAT THE DRIVER SHOULD BE AWARE OF?
(For Example: Heart Condition, Asthma, Epilepsy, Cancer, Pregnancy, Etc.)

If Yes, Please Describe:_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME _____RELATIONSHIP
ADDRESS _____PHONE
(Signature)