Provider Intake & Release Form for: Transportation, Senior Center, Congregate

Date:	**Staff:**	**AgingIS Entry Date:**

Last Name:	**First Name:**

Phone:	**House #:**	**Street:**
Apt/ Suite/ Bldg.:	**City:**	**State:** **Zip:**
County:	**Rural (RI, Mercer, Henry=No)** ☐Yes ☐No	
Date of Birth:	**Gender:** ☐Male ☐Female ☐Gender Identity-Other ☐Decline to answer	
Township:		
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino	**Primary Race:** ☐White ☐Black/African American ☐American Indian or Alaskan Native ☐Asian ☐Native Hawaiian or Pacific Islander	
Number in Household:	**Primary Language:** ☐English ☐Spanish ☐Other: ________________	
Low Income? ☐Yes ☐No Single: $1,561/month Married: $2,114 /month	**Medicaid?** ☐Yes ☐No (Participant has Medicaid coverage or services)	**Are you a Veteran?** ☐Yes ☐No

ADDITIONAL INFORMATION: CONGREGATE ONLY

Special Diet Needs: ☐General ☐Diabetic ☐Other please specify:

RELEASE OF INFORMATION

By my signature or verbal consent, I give __________________permission for my information to be shared

with ________________________________ for the purpose of facilitation of services.

Participant signature: ____________________________ Date: _______________

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Emergency Contact ___________________________________ Relationship _________________________

Phone Number ______________________________

Address ____

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