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: ________________
____

Emergency Contact _____________________________________ Relationship ___________________________

Phone Number _________________________________

Address ____

____