



Dane County Department of Human Services
Transportation Program Intake Form



Privacy Notice to Participant:

The information you are being asked to provide is needed to determine if you are eligible to receive transportation services and to comply with federal reporting requirements. This information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your transportation program intake form and request changes to assure accuracy.

Name: _____ **Today's Date:** ____/____/____

Birthdate: ____/____/____

Address:

Street Address

City/State/Zip Code

Telephone Numbers: Home: _____ Cell: _____ Work: _____

Do you have a disability? Yes No **Other Phone:** _____

Are you applying for a bus pass? Yes No

Purpose for bus pass? _____

Please check all items you use when traveling?

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Service animal |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Power wheelchair | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Power scooter | <input type="checkbox"/> None |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Oxygen tank | |

Do you travel with a personal care attendant? Yes No Sometimes

If you use a wheelchair or scooter, are you able to transfer into a car seat? Yes No
.....a Minivan? Yes No

If you use a wheelchair or scooter, is it wider than 30 inches? Yes No
.....longer than 48 inches? Yes No
..... more than 600 pounds when occupied? Yes No

Do you receive Medicare? Yes No

Do you receive Medical Assistance/Medicaid/MA (Forward Card)? Yes No

What Long Term Care Support program do you currently participate in?

- | | | | |
|------------------------------|--------------------------|---------------------------------------|--------------------------|
| Family Care – My Choice | <input type="checkbox"/> | IRIS – Connections | <input type="checkbox"/> |
| Family Care – Care Wisconsin | <input type="checkbox"/> | IRIS – First Person Care Consultants | <input type="checkbox"/> |
| Family Care – iCare | <input type="checkbox"/> | IRIS – Progressive Community Services | <input type="checkbox"/> |
| Family Care Partnership | | IRIS – TMG | <input type="checkbox"/> |

To determine the number of people in a household, the following qualify and should be included in your count: yourself, your spouse/partner, your children, and your spouse’s children.

How many people live in your household? _____

Income:

- One-person household: income below \$12,060/year? Yes No
- Two-person household: income below \$16,240/year? Yes No
- Three-person household: income below \$20,420/year? Yes No
- Four-person household: income below \$24,600/year? Yes No
- Five-person household: income below \$28,780/year? Yes No

Are you a Veteran? Yes No

Ride/Request Purpose: _____

How long do you anticipate needing transportation assistance? _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Certification: I certify this application has been completed to the best of my knowledge with complete and accurate information. I understand any false statements or omissions of facts relevant to my eligibility for assistance will be considered fraud, and that I may be prosecuted under applicable federal, state or local laws. Furthermore, I understand that assistance is contingent upon availability of funds.

Applicant Date

Mail completed form to:
DCDHS Transportation
1202 Northport Drive
Madison, WI 53704

Questions: 608-242-6489
Fax: 608-242-6531
transportationcallcenter@countyofdane.com