Age Well®
Senior Services
A NONPROFIT SERVING ORANGE COUNTY'S SENIORS

ENROLLMENT FORM FOR TSR /M2 SENIOR NON-EMERGENCY MEDICAL TRANSPORTATION

PLEASE PRINT CLEARLY. ALL FIELDS MUST BE FILLED OUT COMPLETELY. YOU MUST SIGN BOTH REQUIRED FIELDS PRIOR TO MAILING THE FORM BACK FOR PROCESSING. INCOMPLETE FORMS WILL BE RETURNED TO SENDER.

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Male: _____ Female: _____

Address: _____ Apartment/Unit #_____

City: _____ Zip Code: _____ Home Phone: (____) _____

Cell: (____) _____

1. Have you ever applied for OCTA ACCESS? ☐**Yes** ☐**No**
   If yes, were you issued an ID#? _____ ☐**Yes** ☐**No**
   If yes, are you able to utilize **OCTA ACCESS**? ☐**Yes** ☐**No**

2. Do you have any physical or functional limitations? ☐**Yes** ☐**No**

   If yes, please describe: _____

   _____

3. Do you require a mobility device or special equipment for transport? ☐**Yes** ☐**No**

   Please check all that apply:

   Cane _____ Walker _____ Wheelchair _____ Scooter _____ Oxygen _____ Other _____

   If yes, are you able to enter/exit the vehicle without your mobility device? ☐**Yes** ☐**No**

   Are you able to transfer from a wheelchair to seat with/without assistance? ☐**Yes** ☐**No**

4. Will a personal care attendant or assistant be traveling with you? ☐**Yes** ☐**No**

5. Do you require door-to-door assistance? ☐**Yes** ☐**No**

   If yes, please describe reasons why: _____

   _____

6. Please list your primary doctor(s) name & address:

   _____

   _____

7. How often do you anticipate needing to use the transportation service?

   Weekly _____ Monthly _____ Other _____

8. Emergency Contact Name: _____

   Emergency Contact Relationship:_____ Phone #:_____

9. How do you get to your medical appointments now? _____

10. Do you own a vehicle and are you able to drive? ☐**Yes** ☐**No**

OVER

My signature verifies all information in this application to be true.

_____ _____

Applicant signature **Date**

****

The following information is gathered for statistical data only and does not affect your eligibility:

How did you hear about the program? _____

_____

Ethnic background: ☐Asian ☐Black ☐Hispanic ☐White
☐Native American ☐Other

Monthly Income per individual: ***Required** ☐**LESS THAN $1,485/ MONTHLY** ☐**OVER $1,485/ MONTHLY**

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SOUTH COUNTY SENIOR TRANSPORTATION PROGRAM WAIVER

I hereby acknowledge that the transportation is a service provided by Age Well Senior Services and the County of Orange, Office on Aging. I hereby waive the right to make any claims against Age Well Senior Services and the County of Orange, Office on Aging or their officials, employees and volunteers, for any injuries, damages, charges or expenses, including attorney's fees, which might be sustained as a result of my participation in the Age Well Senior Services Transportation Program. I also acknowledge that Age Well Senior Services reserves the right to refuse transportation service.

PLEASE PRINT CLEARLY:

Name: _____ Date: _____

Address: _____

City: _____ Zip Code: _____ Phone: (___) _____

Client Signature _____ ***OR***

Legal Guardian Signature (***COPY OF CERTIFICATION REQUIRED WITH APPLICATION***):

_____

Please return completed forms to the Age Well Senior Services transportation department located at the address at the bottom of the form. Transportation services can be scheduled after all forms have been submitted and approved.

PROGRAM USE ONLY

- Referrals to alternative transportation provided: _____
- Exceptions (temporary, unrestrictive etc.): _____
- Reason referred to OoA I&A: _____
- Need for follow-up contact: _____
- FH waiver issued: _____