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

Race/Ethnicity
American Indian or Alaskan Native ☐
Black or African American ☐
Native Hawaiian or Pacific Islander ☐
Hispanic or Latino ☐
White ☐

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

Other Phone: _____

Do you have a disability? ☐ Yes ☐ No

Are you applying for a bus pass? ☐ Yes ☐ No

Purpose for bus pass? _____

Please check all items you use when traveling?

- ☐ Cane
- ☐ White Cane
- ☐ Walker
- ☐ Crutches
- ☐ Manual wheelchair
- ☐ Power wheelchair
- ☐ Power scooter
- ☐ Oxygen tank
- ☐ Service animal
- ☐ Other _____
- ☐ None

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	☐	IRIS – Connections	☐
Family Care – Care Wisconsin	☐	IRIS – First Person Care Consultants	☐
Family Care – iCare	☐	IRIS – Progressive Community Services	☐
Family Care Partnership	☐	IRIS – TMG	☐

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
2865 N Sherman Avenue
Madison, WI 53704

Questions: 608-242-6489
Fax: 608-240-7401
transportationcallcenter@countyofdane.com