

"ALL INFORMATION IS CONFIDENTIAL"

III-B Transportation Intake Form	Provider Name: MASTER Circle County:
	Date Intake Completed:
Transaction Type: <input type="checkbox"/> New <input type="checkbox"/> Correction <input type="checkbox"/> Update <i>Please highlight correction or updated information</i>	

Items marked with asterisk (*) are required.

*First Name	M.I.	*Last Name	
*Date of Birth _____-_____-_____ Month Day Year	E-mail address:		Unique Participant ID: _____
*Home Phone Number ()		Other Phone Number (cell/work) ()	
*Number and Street of Residential Address			
*City		*State	*Zip Code
Mailing Address (If mailing address is different than Residential Address, list it here.) <input type="checkbox"/> Same as above State/PO Box City/State/Zip			
*Ethnicity <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline to state			

*Race – Check all that apply	
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> <i>Asian (select a box below)</i> <div> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian </div>	<input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> <i>Pacific Islander (select a box below)</i> <div> <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other Pacific Islander </div> <input type="checkbox"/> Decline to state

*Income <input type="checkbox"/> Less than \$1,215 / Month (1 Person) Less than \$1,644 / Month (2 People)			<input type="checkbox"/> More than \$1,216 / Month (1 Person) More than \$1,645 / Month (2 People)	<input type="checkbox"/> Decline to state
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<p>*Rural</p> <p><input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Decline to State</p>	<p><u>Living Arrangement</u></p> <p><input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> Assisted Living/Care Home</p>
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Do you receive Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Veteran Status</u>	
	Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Veteran Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Refer to VA Services? ^{**}	<input type="checkbox"/> Yes <input type="checkbox"/> No

EMERGENCY CONTACT INFORMATION

Name:	Relationship:
Home Phone Number:	Cell Number:
<p>**If you identify as military affiliated, check 'yes' if you consent to A12AA and the CDA transmitting your name and contact information to the Department of Veterans Affairs only for purpose of receiving info on veterans benefits. www.calvet.ca.gov or 1-800-952-5626</p>	

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*What is your Gender? (check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer / Gender Non-binary <input type="checkbox"/> Not listed, please specify: _____ <input type="checkbox"/> Decline to state	*What was your sex at birth? (check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to state	*How do you describe your sexual orientation or sexual identity? (check only one) <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay / Lesbian / Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not listed, please specify: _____ <input type="checkbox"/> Decline to state
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Responses Required to Determine Eligibility

*SUPPORT SERVICES
Do you have an In-Home Support Service (IHSS) caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the IHSS caregiver provide transportation services? <input type="checkbox"/> Yes <input type="checkbox"/> No How many hours per month is allocated for transportation? _____ Do you have someone providing you care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____
*TRAVEL INFORMATION
Are you able to drive? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do you have a valid California driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you own a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Public Transportation available in your area? <input type="checkbox"/> Yes <input type="checkbox"/> No What methods of transportation do you use most often? <input type="checkbox"/> Public transportation <input type="checkbox"/> Family member drives <input type="checkbox"/> Friend, Neighbor, Caregiver drives <input type="checkbox"/> Taxi <input type="checkbox"/> Other _____ Why do you most often travel? <input type="checkbox"/> Medical Appointments <input type="checkbox"/> Hospital <input type="checkbox"/> Pharmacy <input type="checkbox"/> Dialysis <input type="checkbox"/> Senior Center <input type="checkbox"/> Grocery Store <input type="checkbox"/> Family <input type="checkbox"/> Social Activities <input type="checkbox"/> Out of County Medical Appointments: _____
*HEALTH INFORMATION
Are you homebound due to an illness, disability or isolation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, briefly describe: _____ _____ _____
Do you use a mobility aid? (check all that apply): <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Electric Wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> Oxygen Tank <input type="checkbox"/> Power Scooter <input type="checkbox"/> Service Animal <input type="checkbox"/> Walker <input type="checkbox"/> Other _____
Comments: _____ _____ _____ _____

Participant/Person Completing Form -- Signature: _____

Date: _____