|  |  |
| --- | --- |
| **III-B Transportation Intake Form** | **Provider Name: MASTER**  **Circle County:** |
|  | **Date Intake Completed:** |
| **Transaction Type: 🞎 New 🞎 Correction 🞎 Update *Please highlight correction or updated information*** | |

***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.)  🞎 Same as above State/PO Box  City/State/Zip | | | | | | |
| **\*Ethnicity** 🞎 Not Hispanic/Latino 🞎 Hispanic/Latino 🞎 Decline to state | | | | | | |

|  |  |
| --- | --- |
| **\*Race – Check all that apply** | |
| 🞎 American Indian or Alaska Native  🞎 *Asian (select a box below)*   |  |  |  | | --- | --- | --- | | 🞎 Asian Indian | 🞎 Filipino | 🞎 Laotian | | 🞎 Cambodian | 🞎 Japanese | 🞎 Vietnamese | | 🞎 Chinese | 🞎 Korean | 🞎 Other Asian | | 🞎 Black or African American  🞎 White  🞎 *Pacific Islander* *(select a box below)*   |  |  | | --- | --- | | 🞎 Guamanian | 🞎 Samoan | | 🞎 Hawaiian | 🞎 Other Pacific Islander |   🞎 Decline to state |

|  |  |  |
| --- | --- | --- |
| **\*Income**  🞎 Less than $1,215 / Month (1 Person)  Less than $1,644 / Month (2 People) | 🞎 More than $1,216 / Month (1 Person)  More than $1,645 / Month (2 People) | 🞎 Decline to state |

|  |  |
| --- | --- |
| **\*Rural**  🞎 Rural 🞎 Urban 🞎 Decline to State | **Living Arrangement**  🞎 Alone 🞎 With Family 🞎 Assisted Living/Care Home |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do you receive Medi-Cal?** 🞎 Yes 🞎 No | | **Veteran Status**  Veteran 🞎 Yes 🞎 No  Veteran Dependent 🞎 Yes 🞎 No  Refer to VA Services?\*\* 🞎 Yes 🞎 No | |
| **EMERGENCY CONTACT INFORMATION** | | | |
| Name: Relationship: | | | |
| Home Phone Number: Cell Number: | | | |
| \*\*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](http://www.calvet.ca.gov) or 1-800-952-5626 | | | |
| **\*What is your Gender?**  (check only one)  🞎 Male  🞎 Female  🞎 Transgender Female to Male  🞎 Transgender Male to Female  🞎 Genderqueer / Gender Non-binary  🞎 Not listed, please specify:\_\_\_\_\_\_\_\_\_  🞎 Decline to state | **\*What was your sex at birth?**  (check only one)  🞎 Male  🞎 Female  🞎 Decline to state | | \***How do you describe your sexual orientation or sexual identity?** (check only one)  🞎 Straight/Heterosexual  🞎 Bisexual  🞎 Gay / Lesbian / Same-Gender Loving  🞎 Questioning/Unsure  🞎 Not listed, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 Decline to state |

**Responses Required to Determine Eligibility**

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

**Participant/Person Completing Form -- Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**