



**AMERICAN RED CROSS OF GREATER COLUMBUS  
COMMUNITY TRANSPORTATION PROGRAM  
CLIENT REGISTRATION FORM**

**ALL AREAS OF THIS FORM MUST BE FILLED IN COMPLETELY & LEGIBLY  
YOU MUST BE 60 YEARS OF AGE - OR OLDER - TO QUALIFY**

Client Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Male \_\_ Female \_\_ Married \_\_ Living Alone: Yes \_\_ No \_\_

Last 4 digits of Social Security # (required) : XXX - XX - \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_

Relationship: \_\_\_\_\_ phone number: \_\_\_\_\_

Does the client consider themselves: (*Please check all that apply*)

African-American     American Indian/Native Alaskan     Asian

Hispanic     Indian     Multiple     Other     White

Do you have any special needs: (*Please check all that apply*)

- Walker     Cane     Oxygen     Blind/Visually Imp.     Deaf/Hearing Imp.
- Need assistance getting into & out of the car?     Yes     No

**Wheelchair clients (*please check all that apply*)**

Does the client's residence have a ramp?     Yes     No

(\* WC clients with more than 2 steps must have a ramp for our service)

- Manual Wheelchair (*but able to transfer into a car*)
- Manual Wheelchair (*need lift-van*)     Extra Wide Wheelchair (*need lift-van*)
- Electric Wheelchair (*need lift-van*)     Scooter/Power Chair (*need lift-van*)



The following poverty guidelines were released January 20, 2011 by the U.S. Department of Health and Human Services. These figures are to be used to identify clients as Low Income Age 60 and Older.

Source: **Federal Register, Vol. 76, No.13, January 20, 2011, pages 3637-3638, AoA-Professionals and Providers – Aging Network – 2011 Poverty Guidelines** [www.aoa.gov/prof/poverty\\_guidelines/poverty\\_guidelines.asp](http://www.aoa.gov/prof/poverty_guidelines/poverty_guidelines.asp)

Please circle all that apply in the following 3 columns:

<u>Number of People/ Average Family Unit</u>	<u>Maximum Annual Income</u>	<u>Maximum Monthly</u>	
1	\$ 10,890.00	\$ 907.50	
2	14,710.00	1,225.83	
3	18,530.00	1,544.16	
4	22,350.00	1,862.50	
5	26,170.00	2,180.33	
6	29,990.00	2,499.16	7
	33,810.00	2,817.50	
8	37,630.00	3,135.83	

For each additional occupant, add:      3,820.00

- 1) Monthly Income is determined by self-declaration and without verification.
- 2) Monthly Income is based on the individual receiving service.
- 3) Monthly Income is not to include assets, savings, or property owned by the individual.

Funding for Transportation Services is provided through the Central Ohio Area Agency on Aging-Title 111B Funding, The United Way of Franklin County and Client Contributions.

This information is kept in the strictest confidence and is used only for reporting purposes to our Federal Grant Sources. Donations are always welcome but not requires. All donations received through your contributions will be put back into our transportation program.

Revised 7/20/11- pmc

# DISCLOSURE STATEMENT

The attached Client Registration Form was developed to assist the Ohio Department of Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. All client information obtained from this form will be kept confidential and no personal identifying information about a client will be released to the public without the clients prior written consent, or unless otherwise required under federal law.

The data collected will be forwarded to the Area Agency on Aging and the Ohio Department of Aging to be summarized and reported to the Administration on Aging (AOA) in order to keep both state and federal legislators informed on the effectiveness of senior programs *(as required by the 1992 Older Americans Act reauthorization)*. While all clients receiving services under the Older Americans Act are asked to complete the attached form in full, no client may be denied services for refusing to provide any of the information requested, including social security number.

If you have any questions regarding this statement, please call us at **253-2740 ext 2595**.

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I have read the statement above and understand that the American Red Cross of Greater Columbus Transportation Program will not release any of my personal information without my written consent.

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**Clients Signature**

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**Date**

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I have received the client information and agree that no personal information will be released without written consent from client.

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**Providers Signature (American Red Cross)**

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**Date**

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