All information is CONFIDENTIAL.

Area 12 Agency on Aging IIIB Transportation Intake Form	Provider Name: TUOLUMNE COUNTY TRANSIT AGENCY County: TUOLUMNE
	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 with area code	Other Phone Number with area code (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 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
X Rural ☐ Urban ☐ Decline to State

Living Arrangement
☐ Alone ☐ With Family ☐ Assisted Living/Care Home

Do you receive Medi-Cal? ☐ Yes ☐ No

Are you a
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 or 1-800-952-5626

All information is .

*What is your Gender? (check only one)	*What was your sex at birth? (check only one)	*How do you describe your sexual orientation or sexual identity? (check only one)
☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer / Gender Non-binary ☐ Not listed, please specify:_____ ☐ Decline to state	☐ Male ☐ Female ☐ Decline to state	☐ 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 care for you? ☐ 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 ☐ Dial-a-Ride ☐ 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:**_____