**CANAL WINCHESTER SENIOR TRANSPORTATION PROGRAM**

**Client Information Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Township: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell)

\*Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Current Age \_\_\_\_\_\_\_\_\_

\*Gender: M F \*Race: Black White Other \*Are you a Vet? \_\_\_\_\_yes \_\_\_\_\_no

\*\*\*We do not discriminate against our clients however this information is required for statistical purposes required by our funders.

**IN CASE OF EMERGENCY, NOTIFY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell)

**MEDICAL INFORMATION:**

Physician (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relevant medical/behavioral information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(EX: Seizures/Diabetes/Heart Problems, etc.)

Are you able to step into the van? \_\_\_\_\_yes \_\_\_\_\_no

If no, why are you unable to walk? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, do you have a standard wheelchair? \_\_\_ yes \_\_\_ no. Is it electric? \_\_\_\_yes \_\_\_\_no

(Please note: We are unable to transport clients who must remain in their wheelchairs and have a combined weight exceeding 500lbs).

Do you need a caregiver to accompany you (see client guidelines for details)? \_\_\_\_yes \_\_\_\_no

How did you find out about the program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**-Staff will fill out below-**

Wheelchair/lift van needed? \_\_\_\_\_\_Yes \_\_\_\_\_\_No Caregiver needed? \_\_\_\_\_\_Yes \_\_\_\_\_\_\_ No Canal Winchester School District resident? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

Village of Lithopolis/Corp Limit Resident? \_\_\_\_\_ Yes \_\_\_\_\_\_\_ No

Approved Daily Transportation: \_\_\_\_\_Yes Special Trip **only:** \_\_\_\_\_\_Yes

CRC \_\_\_\_\_\_\_\_ Yes In CW City Limits \_\_\_\_\_\_\_ Yes

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CANAL WINCHESTER SENIOR TRANSPORTATION**

**A PROGRAM OF CANAL WINCHESTER HUMAN SERVICES**

80 Covenant Way, Canal Winchester, Ohio 43110

614-834-4700

**ACKNOWLEDGMENT OF RISKS, LIABILITY RELEASE**

**AND INDEMNIFICATION AGREEMENT**

* I have read and understand all client rules and guidelines for the use of Canal Winchester’s Senior Transportation Program.
* I understand my information can be shared with the grantor of Canal Winchester Human Services.
* I agree to assume any risks inherent in participating in Canal Winchester Human Services and/or City of Canal Winchester sponsored activities and programs.
* I agree to follow all facility, activity or program rules and regulations, and realize that my right to participate may be terminated for not adhering to said rules and regulations.
* I agree to hold harmless and release Canal Winchester Human Services from all claims for liability or legal responsibility for any damage or loss of any kind, including personal property or death, property damage, and economic loss, arising from my participation in the Canal Winchester Senior Transportation Program.
* I have read the Release of Information statement and understand that the information is reported to the Administration on Aging.
* My signature on this form acknowledges that I have received a copy of LifeCare Alliance’s **NOTICE OF USE OF PRIVATE HEALTH INFORMATION**. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by LifeCare Alliance and of my rights with respect to my health information.
* I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Client’s Signature Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Caregiver Signature Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*CW Human Services Staff Date*