Coshocton County Coordinated Transportation Agency
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AAA9 / APS CLIENT REGISTRATION FORM

1. First Name_____ MI_____ Last Name_____

2. Date of Birth ____ / ____ / _____ 3.Age in years: _____ 4.Gender: ◯ Male ◯ Female

5. Mobility (Please choose one):
   - ◯ Ambulatory (Can walk and use Steps to enter Vehicle)
   - ◯ Lift Required (Ambulatory, but need lift to enter shuttle)
   - ◯ *Wheelchair - is your chair: ◯ Power ◯ Manual

   5a. *What is the approximate combined weight of you and your wheelchair? _____ lbs.

6. Language Spoken: ◯ English ◯ Other:_____

7. Race/Ethnicity: ◯ Caucasian(White) ◯ Native American ◯ Asian ◯ Hispanic ◯ African American

8. Do you live alone? ◯ Yes ◯ No

9. Are you in Poverty ◯ Yes ◯ No 10. What is your monthly income? $_____

11. Phone# (_____) _____-_____ 11a. Alt. Phone# (_____)_____-_____

12. Social Security # _____ - _____ - _____ 13. Medicaid # (if applicable) _____

14. Are you considered Disabled by a Medical Professional? ◯ Yes ◯ No

15. Are you Elderly (age 65+)? ◯ Yes ◯ No

16. Special Assistances (Please check all that apply):

☐ Blind ☐ Cane ☐ Hearing Impaired ☐ Oxygen ☐ Walker ☐ Other: _____

17. Home Address: _____

City_____ State _____ Zip_____ County_____

18. Emergency Contact Name: _____ Phone#: (_____)_____-_____

Relationship to you: _____

By signing this form, I am acknowledging that all information is true and correct to the best of my knowledge. I understand that any information provided may be shared with any other department/funder in support of CCCTA provided services to ensure CCCTA is compliant with State and Federal Agencies monitoring requirements. If needed, I authorize CCCTA to verify any information provided.

Client Signature_____ Date _____

Office Signature_____ Date _____

AAA9 Disclosure Statement

The attached participant registration form was developed to assist the Ohio Department of Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. Any participant information obtained from this form will be kept confidential and no personal identifying information (e.g., Name, address, telephone number, ID no., etc) will be released to the public without your expressed written consent, or unless otherwise required under Federal Law.

The data collected (age, sex, race, low-income status, ADL's and IADL's) will be forwarded to the Area Agency on Aging and the Ohio Department on Aging 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 participants receiving services under the Older Americans Act are asked to complete the attached form in full, no participant may be denied services for refusing to provide any of the information requested, including social security number.

If you have any further questions, do not hesitate to ask the staff why this release is necessary.

RELEASE OF INFORMATION:

1. I authorize the information contained in this participant registration assessment form to be used for the purpose of planning or to obtain services to meet my need(s).

2. I authorize release of information to any entity specified by State or Federal laws, HCFA, ODHS, ODA, AAA or any agencies necessary for the purpose of monitoring and/or evaluation.

INFORMATION RECEIVED:

- ✓ Complaint and grievance procedure
- ✓ Participant Rights
- ✓ Participant Financial Responsibility, if applicable
- ✓ Long Term Care Ombudsman Contact Telephone Number
- ✓ Telephone Number of Administrator of Agency Delivering Service(s)
- ✓ Telephone Number of Director of Area Agency on Aging
- ✓ Copy of Service plan, if applicable
- ✓ HIPAA Procedures

I GIVE CONSENT TO RECEIVE SERVICES:

_____

Participant's Signature Date

I have discussed/read/explained the Disclosure Statement with the client:

_____

Employee Signature Date