

RideLink Client Registration Information

Last Name:		First Name:		M.I.		
Street Address:				Apt.		
City:	County:	Zip:	Primary Phone: ()			
Alternate Phone: ()	Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Household Size:	Estimated Household Income: \$					
Are you a Medicaid Recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, do you have a Medicaid HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Race/Ethnicity:	<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian/Pac.Isl.	<input type="checkbox"/> Amer. Ind./Esk./Aleut	<input type="checkbox"/> Other
Multi-racial? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, mark all that apply:	<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian/Pac.Isl.	<input type="checkbox"/> Amer. Ind./Esk/Aleut	<input type="checkbox"/> Other

Disability Information

Disability: A physical or mental impairment that substantially limits one or more major life activity.

Using the definition provided above, would you describe yourself as having a disability? Yes No

Do you use a wheelchair when you travel? Yes No

Do you need assistance getting to and from the vehicle? Yes No

Emergency Contact Information

Last Name:		First Name:		M.I.
Primary Phone: ()		Alternate Phone: ()		
Relationship to Client:				

Confidentiality & Release of Information

I understand that the confidential information I am providing on this form will be used for state and local reporting requirements, program management, quality assurance, public safety and research. No other use of personal identifying information on this form is intended unless I authorize it or a court orders it.

Signature: _____ Date: _____

Agency or Service Provider Use Only

Full Name:		Primary Phone: ()
Agency Affiliation:		
Verbal release secured: <input type="checkbox"/> Yes <input type="checkbox"/> No Date secured:	Form mailed to client: <input type="checkbox"/> Yes <input type="checkbox"/> No Date mailed:	Form faxed to ITP 616-774-1284 <input type="checkbox"/> Yes <input type="checkbox"/> No Date faxed:

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