Balsam Lake Office
Polk Co. Govt. Center, 100 Polk Co. Plaza #60, Balsam Lake, WI 54810
Phone: 715-485-8449 Fax: 715-485-8460

Siren Office
Burnett Co. Govt. Center, 7410 Co. Road K #180, Siren, WI 54872
Phone: 715-349-2100 Fax: 715-349-8644

ELDERLY AND DISABLED TRANSPORTATION PROGRAM APPLICATION 2015

DEMOGRAPHIC INFORMATION

Name ___________________________ _________________ _____ **Date of Birth** ________-________-______
Last First M. I. Mo Day Yr

Address _______________________________________ _______________________ _______ _________
Street/Road City/Town State Zip

Billing Address____
(If different from above)

Phone Number_________________ **Cell Phone** ____________________ **Email** ___________________________

Emergency Contact ____
Name number Relationship

Please provide name, age, and relationship of those living with you ___________________________________
____

Please check the following:

Male_____ Female____

Marital Status: Single_____ Married_____ Divorced _____ Widowed____

Race: White_____ Native American_____ African American _____ Hispanic_____ Asian _____ Pacific Islander ____

Disabled: Yes ____ Temporary _____ Permanent _____
No _____

Veteran: No ______ Yes _____

Do you use the following aids: (check all that apply)
___ Walker ___ Manual wheelchair ___ Crutches
___ Portable oxygen ___ Service dog ___ Personal attendant

Are you able to transfer to a seat with little or no assistance No ____ Yes ___

Assistance needed: _____ curb-to-curb _____ to door _____indoor

Please complete financial information on reverse side.

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FINANCIAL INFORMATION

Medicaid benefits: No ____ Yes ____, if yes, Forward Health # ______________________________

Long Term Care Assistance through Community Care of Central WI (CCCW) or IRIS: No ______ Yes ______

Are you receiving SSI (Supplemental Security Income) or SSDI (Social Security Disability Income) No ____ Yes ____

IF YES - **Please submit your benefits verification form with this form.**

Have you been denied SSI or SSDI benefits No ____ YES ____

IF YES - **Please submit your benefits denial form with this form.**

Choose **OPTION A or OPTION B**.

OPTION A: *I do not wish to divulge my financial information. I agree to pay 29 cents per unloaded mile.*

Signature ____ Date ________________

OPTION B: *I have listed my financial information for the Aging and Disability Resource Center of Northwest Wisconsin. The information will be used to determine my transportation co-pays based upon my ability to pay.*

	Passenger	Spouse
1) Average monthly Income:	$__________________	$_________________
2) Average monthly medical Expenses:	$___________________	$_________________
3) Total Liquid Assets	$__________________	$_________________

1) Average Monthly Income: include your social security, pension, disability, wages, interest/dividends, rental income, and any other income you may receive.
2) Average Monthly Medical Expenses: Include medicine, medical supplies, supplemental health insurance premiums, and dental, doctor or hospital bills. DO NOT INCLUDE medical expenses paid for by Medicare, Medicaid, or other insurance.
3) Total Liquid Assets: include savings, checking, CDS, IRAS, stocks, bonds, trusts, and annuities.

This information is true and complete to the best of my knowledge. I authorize the use of this information by representatives of the Aging and Disability Resource Center of Northwest Wisconsin for the purpose of fare determination. I understand this information will remain confidential.

Signature ____ _ Date _________________

Office use only:
Entered __/__/___ Initials ______ **Policy mailed** __/__/__ Initials ______ **Medicaid verified**___/___/___ Initials ______
Waiver: YES ____ NO ____ Initials _______

Aging and Disability Resource Center of Northwest Wisconsin
Serving Polk & Burnett Counties and the St Croix Chippewa Indians of Wisconsin
TOLL FREE: 877-485-2372 | www.adrcnwwi.org