



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 2019

DEMOGRAPHIC INFORMATION

Name _____ Date of Birth _____
Last First M. I. Mo Day Yr

Address _____
Street/Road City/Town State Zip

County of Residence: Polk Burnett

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 _____

Do you use the following aids: (check all that apply)

___ Walker ___ Manual wheelchair ___ Crutches
___ Portable oxygen ___ Service dog ___ Seat Belt Extender

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

*Our transportation service uses volunteers and their own personal vehicles, which are not handicap accessible, and the drivers can only offer minimal assistance. If our program does not fit your needs, feel free to call our office for other transportation resources

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

Veteran: Yes _____ No _____ (If you check yes, please ask to fill out the Veteran Financial Information)

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 _____
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