For Office Use:
Received: ___ _____
Approved: _____
Denied and reason: _____

301 N Cameron Street, Suite 104, Winchester, VA 22601
540-536-1006 WheelsforWellness@outlook.com
www.Wheels4Wellness.org
www.facebook.com/WheelsforWellness

New Client Application

General Information

Applicant Name: Date of Birth:

Address:

Email address:

Home Phone: Cell Phone:

Location of/Directions to your home from Winchester City:

Pets, if applicable for driver safety reasons Do you smoke?

Sex: Male ☐ Female☐ Prefer to not answer ☐

Marital status: single☐ married☐ separated☐ divorced☐ widow/widower☐

Living arrangement: live alone☐ live with spouse/family☐

live in nursing home ☐ other☐

Number of individuals living in the home:

Communication Barriers

Hearing impaired ☐ Speech impaired ☐

First language if not English:

Mobility if applicable**,** please indicate any equipment used to help with your mobility outside of your home:

Manual wheelchair☐ Power Wheelchair☐ Cane☐ Walker ☐

Portable Oxygen☐ Service animal☐ Other

Please list any mental or physical limitations (including memory loss) so that our volunteers may be in a better position to serve your transport needs:

Medication issues/problems:

☐ adverse reactions/allergies ☐ taking medication on time and as prescribed

Health history that may have an impact on mobility or eligibility as a new client:

Please indicate what physicians/facilities for which you are requesting transportation assistance:

Primary Care Physician Phone

Address

Specialist Phone

Address

Specialist Phone

Address

Social Worker **Home Health Agency**

Case Manager **Informal Caregiver**

Family or Emergency Contact:

Name Relationship

Address Phone

Phone

Name Relationship

Address Phone

Phone

How often are you in contact with family or friends?

Daily☐ Weekly☐ Monthly☐ Less than once a month☐ Never☐

Are family and friends available to drive you to medical appointments?

How have you been getting to medical appointments:

Income

After taxes, what range is your monthly (family) income

$457 or less ☐ $458-$1,249 ☐ $1,250-$1,666 ☐ $1,667 or more ☐

Insurance Coverage

Medicaid/eligible ☐ Medicare ☐ Private ☐

Other

If you have Medicaid coverage, are you eligible for Logisticare transportation?

I, have provided accurate information to the best of my knowledge and I have read and understand the Faith in Action client guidelines.

_____

Signature Date

Optional Demographic Information:
Information from this section is used for statistical and confidential reporting purposes only

Ethnicity: African-American Asian/Pacific Islander Latino

Native American Caucasian Other

Congregation: _____ Are you a Veteran? _____

Education level: __ non high school graduate __ high school graduate __ college graduate

Would you like a referral to the appropriate agency for services listed below or more information?

No	Yes		No	Yes	
		Case Management			Legal
		Adult Day Care			Mental Health (inpatient/outpatient)
		Congregate Meals/Senior Center			Personal Care
		Visitor check-in or phone call			Transportation
		Home Delivered Meals			Other
		Home Repairs			

CONSENT TO EXCHANGE INFORMAITON

I understand that different agencies provide services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so that it will be easier for them to work together effectively to provide or coordinate these services for benefits. My signature below is my consent to share information for that purpose.

The following agencies are able to exchange information:

Faith in Action DBA Wheels for Wellness

Volunteers (Drivers)

Physician's office

Family Member/Caregiver

Department of Social Services

This information is to be exchanged only for service coordination, anonymous data reporting and determining eligibility. Information will be shared by written information, in meetings, by phone or computer.

I can withdraw this consent at any time by information the referring agency. At that point, listed agencies will be instructed not to share information that I have provided.

Signature: _____ Date: _____