Wheels for Wellness
Formerly known as Faith in Action

301 N Cameron St. #104,
Winchester, VA 22601-4805
540-536-1006
www.Wheels4Wellness.org Facebook: Wheels for Wellness

New Client Application for One-Time Transport

General Information

Applicant Name: _____ Date of Birth: _____

Address: _____

Email address: _____

Home Phone: _____ Cell Phone: _____

Sex: Male Female

Marital status: single married separated divorced widow/widower

Living arrangement: live alone live with spouse/family live in nursing home other

Communication Barriers

_____ Hearing impaired _____ Speech impaired

First language if not English: _____

Mobility if applicable**,** please circle 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 Faith in Action may be in a better position to serve your transport needs:

_____

Primary Care Physician _____ Phone _____

Address _____

Family or Emergency Contact:

Name _____ Relationship _____

Address _____ Phone _____

_____ Phone _____

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, please circle/list

Medicaid/eligible Medicare Uninsured

Private: _____ Other _____

If you have Medicaid coverage, are you eligible for Logisticare/Modivcare 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

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:

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: _____