Site:
(office use only)
_____

Erie County Senior Van Transportation
Over 60 Participant Registration

Registration #
(office use only)
_____

Date_____ All information given by participant on this form will remain **CONFIDENTIAL**.

Please complete both sides of the entire form.

Please Print

Name _____Date of Birth_____Age____
Last Name First Name MI
Street/Unit_____City_____NY, Zip_____

Telephone_____
Are you the spouse of another participant? No ☐ Yes ☐ If Yes, who? _____
Do you receive Medicaid? No ☐ Yes ☐ If Yes, CIN# _____
1 Person Monthly Income: Less than $1073___$1074-$1342___$1343-$1610___ Greater than $1610___

2 Person Monthly Income: Less than $1452___$1453-$1815___$1816-$2178___ Greater than $2178___

EMERGENCY INFORMATION: In case of an emergency, whom shall we notify?	**MEDICAL INFORMATION:**
Name:_____ Address:_____ City:_____ Zip Code:_____ Relationship:_____ Phone_____	Physician's Full Name:_____ Address:_____ City:_____ Zip Code:_____ Physician's Telephone Number: ( )_____

Please answer **all** the following questions. The purpose is to gather basic characteristics about the people we serve. Answering the questions will **NOT** affect your eligibility for receiving services.

1. Sex: Male ☐ Female ☐

2. Are you a USA Veteran? Yes ☐ No ☐

3. Are you? Married ☐ Single ☐ Widowed ☐ Divorced ☐

4. Number of people living in household (including yourself) _____

5. Do you live alone? Yes ☐ No, with spouse ☐ No, with relatives ☐ No, with non-relatives ☐

6. Race/Ethnicity: White, not Hispanic ☐ Hispanic or Latino ☐ Black, Not Hispanic ☐
Asian ☐ American Indian/Alaskan Native ☐ Native Haw/Pac Islander ☐ Other ☐

7. Do you consider yourself frail/disabled? ** Yes ☐ No ☐

8. Do you use a wheelchair? Yes ☐ No ☐

**A person who has a physical or mental disability which substantially limits one or more life activities.

Informed Consent to Capture and Record Personal Information (Aging Services)

I consent to the Erie County Department for the Aging saving personal information provided by me or my authorized representative in the Statewide Client Data System maintained by the New York State Office for the Aging. This personal information may include, but is not limited to, medical records, employment records, government records, and any other information collected from me by Erie County Department for the Aging.

I understand that this information is being collected to help in providing services and to identify other services which I may benefit from. I understand that the authority to provide these services and to collect my information for these purposes is found in the Older Americans Act and the New York State Elder Law.

I understand that, consistent with New York State's Personal Privacy Protection Law, my personal information will be treated as confidential and will not be disclosed without my further informed consent for disclosure.

I acknowledge that informed consent has been explained to me and that I understand the need for the information being recorded and that there are laws and regulations protecting the confidentiality of authorized information.

I understand that signing this authorization is voluntary. Refusal to do so may make it difficult to make referrals on my behalf. I have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon this authorization, by writing to Erie County Department for the Aging.

_____ _____

Signature Date

_____

Print