COMMUNITY SERVICES
TRIPS

Print Form

APPLICATION FOR TRIPS NUTRITION TRANSPORTATION SERVICES

Please print clearly. All fields must be completed and the last page must be signed prior to processing your application. Incomplete applications will be returned.

APPLICANT INFORMATION

LAST NAME*	FIRST NAME*		DATE OF BIRTH
ADDRESS*			HOME PHONE*
CITY	STATE	ZIP	MOBILE PHONE*
EMAIL*			GENDER
			☐ MALE ☐ FEMALE
LIVING ARRANGEMENTS			HOME PET
☐ ALONE ☐ WITH OTHERS ☐ DECLINED TO STATE			☐ YES; Specify: ☐ NO

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME*		EMERGENCY CONTACT NAME*	
1.		2.	
RELATIONSHIP*		RELATIONSHIP*	
HOME PHONE*	MOBILE PHONE*	HOME PHONE*	MOBILE PHONE*

PHYSICIAN NAME*			PHONE*
ADDRESS*	CITY	STATE	ZIP

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MEDICAL CONDITIONS

SELECT ANY MEDICAL CONDITIONS/SPECIAL NEEDS

- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ BALANCE/MOBILITY
- ☐ CARDIOVASCULAR
- ☐ COGNITIVE / MEMORY LOSS
- ☐ DEVELOPMENTALLY DISABLED
- ☐ DIABETES
- ☐ DIALYSIS
- ☐ EPILEPSY
- ☐ HEARING LOSS
- ☐ LANGUAGE BARRIERS
- ☐ MOBILITY MOTOR
- ☐ MULTIPLE SCLEROSIS (MS)
- ☐ PARKINSON'S
- ☐ VISUALLY IMPAIRED
- ☐ OTHER: _____

DO YOU REQUIRE A MOBILITY DEVICE OR SPECIAL EQUIPMENT FOR TRANSPORT?

- ☐ NONE
- ☐ CANE
- ☐ ELECTRIC 3-WHEEL SCOOTER
- ☐ ELECTRIC WHEELCHAIR
- ☐ LEG/ARM BRACES
- ☐ OXYGEN
- ☐ SERVICE ANIMAL
- ☐ WALKER
- ☐ WHEELCHAIR
- ☐ OTHER: _____

IF YOU UTILIZE AN ELECTRIC WHEELCHAIR OR SCOOTER, PROVIDE THE FOLLOWING INFORMATION

MAKE _____ WIDTH _____ LENGTH _____

MODEL _____ WEIGHT _____

WILL A PERSONAL CARE ATTENDANT BE TRAVELING WITH YOU?

☐ YES ☐ NO If YES, please provide information below:

PERSONAL CARE ATTENDANT NAME*	CARE ATTENDANT PHONE*

MY SIGNATURE BELOW VERIFIES ALL INFORMATION PROVIDED IN THIS APPLICATION TO BE TRUE.

APPLICANT SIGNATURE* _____

DATE _____

CAREGIVER/GUARDIAN SIGNATURE* (ON BEHALF OF APPLICANT) _____

DATE _____