TRANSPORTATION RIDERS
Release of information

Dear Friends: Each time someone rides in one of our vehicles, we are required by agency and/or funder regulations to request some information. This information is for your benefit in case you should become ill or have some other problem while riding with DART. Our records are CONFIDENTIAL.

Today's Date: _____

First Name:_____ Last Name:_____

Address:_____ APT#:_____

City:_____ State:_____ Zip:_____

Day Phone: (___) _____ Cell Phone: (___)_____

Date of Birth:_____

Emergency Contact # 1:_____

Phone:_____ Relationship to rider:_____

Emergency Contact # 2:_____

Phone:_____ Relationship to rider:_____

Are you on Medicaid: ☐ YES ☐ NO if yes, what is your Medicaid number:_____

Select all that apply

GENDER: ☐ Female ☐ Male ☐ Other

RACE: ☐ Caucasion ☐ Black ☐ Hispanic ☐ American Indian ☐ Asian ☐ Other

DO YOU USE OR REQUIRE: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Oversize Wheelchair

☐ Lift ☐ Oxygen ☐ Car Seat ☐ Booster Seat ☐ Guide animal ☐ Attendant

ARE YOU: ☐ Visually impaired ☐ Hearing impaired

If 60 or older, please also fill in the following:

If only one (1) in family: Is your income under $1012 per month? ☐ Yes or ☐ No

If two (2): Is your income under $1372 per month? ☐ Yes or ☐ No

Rider Signature:_____