|  |  |
| --- | --- |
| Date:       | YVEDDI ROAP Service Application |
| County of Residence: |       |
| Name: |       |
| Street Address: |       |
| City/State/Zip: |       |
| Phone Number: |       |
| Email Address: |       |
| Date of Birth: |       | Last 4 digits of S.S.N.: |       |
|  |
| 1. Do you receive Medicaid? *(If yes, please refer to DSS)*
 | [ ]  YES [ ]  NO |
| 1. Do you have a vehicle?
 | [ ]  YES [ ]  NO |
| 1. Do you have a Driver’s License?
 | [ ]  YES [ ]  NO |
| 1. Do you have a friend or relative that can take you to your appointments?
 | [ ]  YES [ ]  NO |
| 1. Do you have a life threatening medical conditions? (if so, please describe)
 | [ ]  YES [ ]  NO |
|       |
| 1. Name/Address of doctor or agency who can verify the medical condition.
 |
|       |
| 1. Do you have any disabling conditions? (if yes, please describe)
 | [ ]  YES [ ]  NO |
|       |
| 1. Do you use a wheelchair?
 | [ ]  YES [ ]  NO |
| 1. Do you use any other assistive devices such as oxygen, a cane, or a walker?
 | [ ]  YES [ ]  NO |
| 1. Are you able to climb stairs?
 | [ ]  YES [ ]  NO |
| 1. Does a caregiver go with you to appointments?
 | [ ]  YES [ ]  NO |
| 1. How often will you need transportation?
 |
| *Frequency:* | *Location/Address:* | *Reason* |
|       |       |       |
|       |       |       |
|       |       |       |
| **EMERGENCY CONTACT INFORMATION** |
| Name: |       |
| Address: |       |
| Phone: |       |
| Work Phone: |       |
| Relation to client: | [ ]  Relative [ ]  Friend [ ]  Caregiver [ ]  Other        |
| **Applicant Signature:** |  | **Date:** |  |
| FOR OFFICE USE ONLY |
| Approved for: | [ ]  RGP [ ]  E & D |
| Employee Name: |       |