**BART Consumer Registration Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Section 1 – Complete for all Participants

# Category (check one): \_\_\_\_ 65 or better

#

# Prefix (circle one): Mr. Mrs. Ms. Residential Address:

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suffix (circle one): Jr. Sr. Town:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maiden Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AKA Name (nickname):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (circle one): Married Widowed Township/Borough:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Divorced Single Legally Separated

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Mailing Address same as Residential**

 **(circle one): Yes No**

 **If no, provide mailng address here:**

Gender (circle one): Female Male P.O. Box or Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(full or last 4 numbers)** Example: xxx/xx/xxxx

 Town:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will you have a riding companion? Yes No

If yes, provide name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete revise side

**BART Consumer Registration Form \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 2** - Complete for 60+ Participants Characteristics:

Federal & State Reporting Requirements Abused/Neglected/Exploited: [ ] Yes [ ] No

Circle Answers to the following questions Cognitive Impairment [ ] Unknown

Ethnicity [ ] None [ ] Moderate [ ] Mild [ ] Severe

Hispanic or Latino: [ ]  Yes [ ]  No [ ]  Unknown

In Poverty: [ ]  Yes [ ]  No Disabled: [ ]  Yes [ ]  No

2015 Poverty Levels

 1 Person 981/Month Female Head of Household: [ ] Yes [ ] No

 2 Persons 1,328/Month

 3 Persons 1,674/Month Frail [ ] Yes [ ] No

 4 Persons 2,021/Month

 Each Additional 347/Month Homebound: [ ] Yes [ ] No

Lives Alone: [ ]  Yes [ ]  No Medicare Eligible: [ ] Yes [ ] No

High Nutritional Risk: [ ]  Yes [ ]  No Receiving Social Security: [ ] Yes [ ] No

Ethnic Race: State Resident: [ ] Yes [ ] No

 [ ]  American Indian

 [ ]  Asian Tribal [ ] Yes [ ] No

 [ ]  Black/African American

 [ ]  Native Hawaiian/Other Pacific Islander Understands English: [ ] Yes [ ] No

 [ ]  Non-Minority (White – Non-Hispanic)

 [ ]  Other US Citizen: [ ] Yes [ ] No

 [ ]  White - Hispanic

 Veteran: [ ] Yes [ ] No

**Emergency Contact (local family, friend, neighbor)** Veteran Dependent: [ ] Yes [ ] No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language Other than English:

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #\_(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consumer/Consumer Representative

Work or Cell Phone # \_\_(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*I certify that the information provided above

 is true and correct to the best of my

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ knowledge

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Consumer Signature

**AGE VERIFICATION – HEALTH FORM**

**OLDER ADULT - FOR THE BUTLER AREA & RURAL TRANSIT**

(BART)

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print legibly)

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL ASSISTANCE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please verify your age by providing a copy of one of the following items. **Applications missing this information will not be processed.** So that we may better serve you, please indicate any health concerns on the checklist on the back.

**Sign and return this form and a copy of your age verification in the envelope provided. (**BART Applications, C/O Butler County Area Agency on Aging, 111 Sunnyview Circle, Bldg 3, Butler, PA 16001)

**ANY QUESTIONS CALL 724-282-3008 OR TOLL FREE 1.888-367-2434**

\_\_\_\_\_BIRTH CERTIFICATE \_\_\_\_\_PASSPORT

\_\_\_\_\_BAPTISMAL CERTIFICATE \_\_\_\_\_NATURALIZATION PAPERS

\_\_\_\_\_DRIVER’S LICENSE \_\_\_\_\_**PACE** IDENTIFICATION CARD

\_\_\_\_\_PA. PHOTO I D CARD \_\_\_\_\_VETERAN’S UNIVERSAL

\_\_\_\_\_ARMED FORCES DISCHARGE \_\_\_\_\_RESIDENT ALIEN CARD ISSUED

\_\_\_\_\_STATEMENT OF AGE FROM BY U.S. DEPT OF IMMIGRATION

 SOCIAL SECUITY OFFICE AND NATURALIZATION

 FOR MEDICARE RECIPIENT

I certify that the information provided here in true and correct to be best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF APPLICANT DATE

**Complete reverse side**

*Agency Assessment Notes & Comments:*

*Date Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date BART Advised \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date Consumer notified \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any/all personal information we should know about to better serve you:

\_\_\_ Alzheimer’s – riding alone

\_\_\_ Alzheimer’s – riding with companion

\_\_\_ Blind – riding alone

\_\_\_ Blind – riding with a companion

\_\_\_ Bad eyesight

\_\_\_ Dementia

\_\_\_ Diabetes

\_\_\_ Epilepsy

\_\_\_ Frail

\_\_\_ Hearing impaired

\_\_\_ Use Oxygen

\_\_\_ Use a walker

\_\_\_ Use cane

\_\_\_ Use crutches

\_\_\_ Use **ELECTRIC** wheel chair

\_\_\_ Use **XL** wheel chair

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_