



Grundy Transit System Client Information

Date ____/____/____ Are you a Veteran? Yes ____ No ____

Name (Last) _____ (First) _____

Address _____ Apt. # _____

City _____ State ____ Zip _____ County _____

Phone/Home (____) ____-____ Cell (____) ____-____

Sex: Male ____ Female ____ Birth Date ____/____/____

Preferred Language _____

Do you need assistance getting on/off the bus? Yes ____ No ____

Do you require door to door service? Yes ____ No ____

Do you use a mobility aid such as a wheelchair, cane, walker, motorized scooter, or portable CO2?

Please describe: _____

Do you have a Personal Care Assistant? Yes ____ No ____

Do you have Medicaid: Yes ____ No ____ **Medicaid #:** _____

Household Composition:

Lives Alone ____ With Children ____ With Non-Relatives ____

With Spouse ____ With Relatives ____ Nursing Home ____ Assisted Living ____

Do you have any conditions that the driver should be aware of? If yes, please list below.

In case of emergency, please notify:

Name: _____ **Phone #:** _____

Notes: _____