|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: |  | | | | | | | | | |