

Manning Valley & Area Community Transport Group Inc.
Section 3 Service Delivery
DOC 3.03-1-10-v5 Registration Form

TRANSPORT REGISTRATION FORM - CONFIDENTIAL

If you are over the age of 65 years, please contact myagedcare on 1800 200 422 to register for Community Transport

PART A Please complete information and circle correct answer where appropriate.

Given Name:		Preferred Name:		Family Name:	
Date of Birth: / /		Male / Female / Other		Indigenous or Torres Strait Islander YES / NO	
Contact number:			Mobile:		
Country of Birth:	Main language spoken at home:		Do you have cultural or linguistic needs? YES / NO If yes please state:		
Address(for transport pick-ups)					
Postal Address: (if different from above)					
Email:					

PART B – Emergency Information

Emergency Contact Name:		Telephone:		Relationship to you	
Doctors Name:		Contact number:		Medicare Number:	

PART C – Type of Income:

Do you receive an Aged Pension YES / NO Full Pension / Part Pension / Other (<i>please state</i>) (please circle and write number)	
Are you receiving a DVA Pension : Gold / White Card / orange / other (<i>please state</i>) <i>DVA number</i>	
Are you on a Homecare Package: YES / NO if Yes contact details for provider	
Are you on an NDIS package: YES / NO if Yes contact details for provider	
NDIS number:	
Are you receiving any benefits from Centrelink <i>if yes please state and write number</i>)	

Please turn over

PART D- Accommodation

Are you a home owner YES / NO	Do you rent Private rental / Public Housing / Other (please state)	Do you live alone?: YES / NO	Whom do you live with?
Do you have a carer who will need to travel with you? YES / NO if yes please write details below			

Please note, if you do have a carer, they will also have to register for transport to travel with you.

PART E – Your abilities for transport requirements

The following Information will be used to assess the level of assistance you might require when travelling with Community Transport.

Do you use a Walking Frame YES / NO	Do you use a Walking stick YES / NO
Do you have a wheelchair YES / NO if yes, please state type of chair. Eg; Electric / Bariatric / Push Chair	Do you use Oxygen? If yes please circle Tank /Cylinder or Concentrator
Do you have any health issues that will affect service delivery? <input type="checkbox"/> Visual impairment <input type="checkbox"/> Poor Balance <input type="checkbox"/> Memory loss <input type="checkbox"/> Incontinence <input type="checkbox"/> Obesity <input type="checkbox"/> Breathing Difficulties <input type="checkbox"/> Other (please state).....	

Can you move independently? From home to vehicle	YES / NO
Can you manage 2 to 3 steps independently?	YES / NO
Can you manage alone at your destination?	YES / NO
Are there any issues for a vehicle to your home? Eg: no driveway, narrow driveway	YES / NO

CONSENT STATEMENT

I, _____ understand that the information I have provided is correct.
 I understand Manning Valley & Area Community Transport will retain my personal information on file for the purpose of providing me with a safe service.
 I understand Manning Valley & Area Community Transport are required to report, non-identifying information to funding bodies for funding, planning and statistical purposes.
 I understand that from time to time photos or videos may be taken during the course of our activities and used for promotional purposes.

Signature Client: _____ Date: _____

Office use only: Handbook sent to client YES / NO sent by: _____ Date sent _____ Date returned: _____ Is this person a MAC client: YES / NO if yes, Aged Care User ID _____ Date referred by MAC: _____ Date Accepted: _____ Funding Source _____ Routmatch ID _____ Date entered into Routematch : _____ Entered by _____ Notes: _____
