RIDER PROFILE- VOLUNTEER DRIVERS PROGRAM

☐ Refer to VOUCHER PROGRAM

NF Staff Bao

☒ AMBULATORY
☐ NON-AMBULATORY

Referral Date _____ **Service start date** _____ **Home Phone/TTY** - _____

Name _____ **Cell Phone** - _____

Address _____ **Phone (other)** _____

City _____ **State** WI **Zip** _____ **E-Mail** _____

County _____ **Date of Birth** _____ **Gender** ☐ Male ☒ Female

Ethnicity
- ☒ White
- ☐ Am Ind/ Alaska Nat
- ☐ Black /Af Am
- ☐ Hispanic or Latino
- ☐ Hawaiian/ Pac Isl
- ☐ Asian
- ☐ Unknown

Veteran: ☐ Yes ☒ No

Vehicle required:
- ☐ 2-Door
- ☐ 4-Door
- ☐ Low Profile

Emergency Contact/ Relationship
NAME: _____
PHONE: - _____

NAME: _____
PHONE: _____

Will this person bring a companion (Friend, Family Member, Staff) for their rides? ☐ Yes ☒ No ☐ Service Animal

Uses Cane, Walker or Wheelchair? ☐ Yes ☒ No If Yes, Which one? _____

Can transfer independently in/out of walker/wheelchair? ☒ Yes ☐ No If No, what type of assistance will they require: _____

PLEASE CHECK ALL THAT APPLY:

PHYSICAL
- ☐ ALS
- ☐ Amputation
- ☐ Arthritic Conditions
- ☐ Asthma/COPD/Lung Disease
- ☐ Back Injury
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Degenerative Disease
- ☐ Diabetes
- ☐ Epilepsy/Seizure Disorder
- ☐ Frail Elderly
- ☐ Heart Disease/ Condition
- ☐ HIV/AIDS/Blood Disorder
- ☐ Kidney Disease
- ☐ Morbid Obesity
- ☐ Multi-Chemical Sensitivities
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Neurological
- ☐ Orthopedic
- ☐ Parkinson's
- ☐ Physical-Other(note below)
- ☐ Polio/Post Polio
- ☐ Spinal Cord Injury
- ☐ Stroke/Cardiovascular
- ☐ Substance Abuse

HEARING
- ☐ Deaf
- ☐ Hard of Hearing

VISION
- ☐ Blind
- ☐ Vision Loss

COGNITIVE
- ☐ Alzheimer's/Dementia
- ☐ Autism/Asperger's
- ☐ Cognitive
- ☐ Learning Disability
- ☐ Traumatic Brain Injury
- ☐ Mental/Emotional

Current Transportation
- ☐ Spouse
- ☐ Other Family members
- ☐ Friends
- ☐ Other Provider (Who?)
- ☐ Have Own Vehicle

Rides Needed
- ☐ Independent Living Activities
- ☐ Medical
- ☐ Work
- ☐ School
- ☒ Social

Billing Agency
- ☐ NF
- ☐ #85.21
- ☐ SSP (Pierce County)
- ☐ Self-Pay
- ☐ Inclusa
- ☐ CWI / MCFC
- ☐ IRIS
- ☐ DVR
- ☐ Lakeland
- ☐ WRRWC
- ☐ Midway (Dunn County)

Please list any other medical conditions or allergies you may have:

Learned of Services

Family/Friend

Managed Care Team Info

CRC Name: _____
Phone: _____
HWC Name: _____
Phone: _____
Hub Office: _____
Hub Office Phone: _____

Comments / Specific Needs

SUBMIT FORM TO COMPASSIL

Office Use Only:

Date Entered: _____
Date Rider Letter Mailed: _____

Service End-Date: _____ ☐ DOD

Revised 4/2021