GCID # _____

The Grand Connection Qualification Application

1821 S. STATE HIGHWAY 161, GRAND PRAIRIE, TX. 75051
Office 972-237-8546 FAX 972-237-8544

Print, complete and mail this application to The Grand Connection

Part I – General Information

Name: _____

Address: _____

_____

City: Grand Prairie State: Texas Zip: _____

Sex: M F Social Security Number: _____

Date of Birth: _____ Age: ___

Home Phone: (972) _____

Part II – Emergency Contact

***Primary Emergency Contact*: _____**

Relationship: _____

Phone Number: _____

***Secondary Emergency Contact*: _____**

Relationship: _____

Phone Number: _____

Page 2 of Application

Part III – Health Information

A. Type(s) of Disability: Mark all that apply

_____ Allergy
_____ Alzheimer's
_____ Amputee
_____ Arthritis
_____ Blind
_____ Cancer
_____ Cerebral Palsy
_____ Developmental Disabled
_____ Deaf
_____ Depression
_____ Dialysis
_____ Diabetes
_____ Epilepsy
_____ Broken bones
_____ Head injury / trauma
_____ Heart
_____ HIV / AIDS
_____ Kidney / Renal
_____ Liver
_____ Muscular Dystrophy
_____ Mental Illness
_____ Multiple Sclerosis
_____ Psychiatric disorder
_____ Respiratory / Breathing
_____ Seizure
_____ Skin
_____ Spinal injury
_____ Stroke
_____ Thyroid
_____ Other (_____)

B. Mobility Aides (Check all that apply)

_____ Cane
_____ Walker
_____ Guide Dog
_____ Crutches
Wheelchair:
_____ Manual
_____ Electric: Large Wheels
_____ Electric: Small Wheels
_____ Scooter: Size (_____)
_____ Other (_____)

C. Type of Transportation needed from The Grand Connection:

_____ Nutrition Center _____ Medical _____ School
_____ Dialysis _____ Grocery _____ Work
_____ Medicaid (Medicaid Number _____)

D. Where did you learn about the Grand Connection?

Part IV – Authorization for the Release of Information

I verify that the above information is true and correct to the best of my knowledge. I also authorize the personnel of The Grand Connection to obtain verification of any information given in this application and to obtain pertinent medical information necessary for clarification of ridership eligibility.

I, the undersigned, have read and understand the "Authorization for the Release of Information" section above and agree to all the terms and conditions contained in these statements. I voluntarily execute and agree to these statements with full knowledge of their significance.

DATED THIS _____ DAY OF _____, 20_____ .

_____ _____

Applicant Signature Date

_____ _____

Witness Signature Date

Page 4 of Application

Part V – Disability Certification: To be completed by a licensed health care professional for applicants qualifying because of physical or mental disabilities.

► Failure to complete this portion may lead to ineligibility of applicant.

► An individual wishing to be certified with the Grand Connection must be at least 60 years of age or be transportation dependent by virtue of a physical or mental disability.

IF TRANSPORTATION NEEDS TO BE PROVIDED TO THIS APPLICANT, PLEASE VERIFY THE INFORMATION PROVIDED IN THIS APPLICATION AND COMPLETE THE INFORMATION BELOW:

1. This application (Circle one) **does / does not** meet the criteria of being transportation dependent as described above.

2. Description of physical or mental disability and diagnosis: _____
_____

   If applicable, what is the patient's mental level? _____
   Will the patient present a behavioral problem during transportation?
   Circle one: Yes No

3. Is the disability permanent? Circle one: Yes No
   If temporary, what is approximate date of recovery? _____

4. If applicant uses a wheelchair, can he/she independently transfer from wheelchair to a passenger seat? Circle one: Yes No

Health Care Professional's Name: _____
Address: _____
_____
City: _____ State: _____ Zip: _____
Phone Number: _____

_____ _____
Physician's Signature Date