



Request for Senior Center Transportation
COASTAL COMMUNITY CENTER
 180 Marine St, St. Augustine, FL 32084
 904-209-3696

Request Details (please check all that apply):

<input type="checkbox"/> NEW REQUEST <input type="checkbox"/> Client No Longer Drives <input type="checkbox"/> Client lives alone <input type="checkbox"/> Client lives with other but other is not able/available to transport CL to center
Notes:

Subscription Details (please circle all applicable)

MON	TUES	WED	THURS	FRI
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Start Date:		End Date or Ongoing (circle one) End Date if applicable:
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Client Details

LAST Name:	FIRST Name:
Date of Birth: ____ - ____ - ____	Address:
State: Zipcode:	City:
Client Phone #:	Gender (check one): <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Mobility (check one): <input type="checkbox"/> Ambulatory <input type="checkbox"/> Walker (but requires a lift) <input type="checkbox"/> Wheelchair (Regular) <input type="checkbox"/> Wheelchair (Motorized) <input type="checkbox"/> Wheelchair (Extra-Wide) <input type="checkbox"/> Wheelchair (Extended-Leg) <input type="checkbox"/> Scooter (Note: Clients must be able to operate themselves)	Emergency Contact Name:
	Emergency Contact Relation to Client:
	Emergency Contact #:
Bill to the following Funding Source: Nutrition	Notes:

Senior Center Program Coordinator:

Sign.:	Date:
Notes:	

Transportation Dept. Representative:

Sign.:	Date:	<input type="checkbox"/> Seeking Approval
Return Fax #:	Time:	<input type="checkbox"/> Approved
Notes:		<input type="checkbox"/> Not Approved