

JEWISH COMMUNITY COUNCIL OF GREATER CONEY ISLAND

3001 West 37th Street Brooklyn New York, 11224 · Ph: (718) 449-5000 x 1 · Fax: (347) 946-6155

E-mail: seniortrips@jccgci.org

JCCGCI ID#

Referred By: _____

CLIENT ELIGIBILITY CERTIFICATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Maiden Name: _____ Gender: Male Female

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Check off Services of Interest

- Homecare
- Transportation
- Case Assistance/Access
- Friendly Visiting
- Telephone Reassurance
- Socialization Programs

CD / NYCCD

AD / COND / SD

Date of Birth

Month Day Year
/ /

Place of Birth

Town/City Country
/

Social Security Number

Ethnicity

- Asian Black
- Hispanic White Other

Marital Status

- Single Divorced
- Married Widowed

Living in Household

Housing

- Rent Homeless
- Own Other

Homebound

- Yes
- No

Do you use a...?

- Cane Walker
- Wheel Chair None

Medical Conditions/Need for Transportation

Visual Impairments

- Macular Degeneration
- Legally Blind None
- Other _____

Hearing Impairments

- Use hearing aid Deaf
- Other _____ None

Source of Income

- Social Security SSI Pension Job
- Other Holocaust Compensation

Primary Language

TOTAL Monthly Income – for individual only, not spouse

- \$0-\$439 \$550-\$599 \$750-\$899 \$1000-\$1099 \$1300-\$1499
- \$440-\$549 \$600-\$749 \$900-\$999 \$1100-\$1299 \$1500 or More

Monthly Income – Individual, not incl Government Income / Pension

- \$0-\$439 \$550-\$599 \$750-\$899 \$1000-\$1099 \$1300-\$1499
- \$440-\$549 \$600-\$749 \$900-\$999 \$1100-\$1299 \$1500 or More

Do you have/receive...?

- Medicaid Food Stamps
- Meals-on-Wheels Medicare
- Access-a-Ride
- Services from another Agency

Please Specify which Agency: _____
Please Specify which Services: _____

U.S Veteran

- Yes No

Emergency Contacts

1) Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Tel: (____) _____ - _____ Cell: (____) _____ - _____ Relationship: _____ Email: _____

2) Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Tel: (____) _____ - _____ Cell: (____) _____ - _____ Relationship: _____ Email: _____

Additional Information Needed:

PLEASE INCLUDE A COPY OF STATE ISSUED ID SHOWING PROOF OF AGE AND ADDRESS

- ▶ PLEASE SUBMIT A COPY OF STATE ID or DRIVER LICENSE or DOCUMENT CONFIRMING AGE AND BROOKLYN RESIDENCE;
- ▶ PLEASE SUBMIT A COPY OF MEDICAID/MEDICARE CARD;
- ▶ FOR AMBULETTE PLEASE SUBMIT A LETTER FROM DOCTOR CONFIRMING NEED FOR WHELCHAIR ACCESSIBLE VEHICLE;

Date of Emmigration to US

Month/Year ____/____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Client's Signature: _____ Date: _____

Case Worker's Name: _____ Agency: _____ Telephone: _____