

**TRANSPORTATION APPLICATION**  
**WEST CENTRAL MINNESOTA COMMUNITIES ACTION, INC.**

Last Name \_\_\_\_\_ Date \_\_\_\_\_

First Name, M.I. \_\_\_\_\_  Own Home  Rent  Homeless  Other

Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_ Primary Language \_\_\_\_\_

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Street Address \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_ County \_\_\_\_\_

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Mailing Address (if different from street address) \_\_\_\_\_ City/State/Zip Code \_\_\_\_\_ County \_\_\_\_\_

**Referral source:** \_\_\_\_\_

**SOURCES OF INCOME AND OTHER ASSISTANCE (Check all those that apply)**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Salary or Wages<br>\$ _____       | <input type="checkbox"/> General Assistance<br>\$ _____ | <input type="checkbox"/> Retirement/Pension<br>\$ _____ | <input type="checkbox"/> Food Stamps<br>\$ _____             |
| <input type="checkbox"/> Alimony/Child Support<br>\$ _____ | <input type="checkbox"/> Unemployment Comp.<br>\$ _____ | <input type="checkbox"/> MSA<br>\$ _____                | <input type="checkbox"/> Housing/Rent Assistance<br>\$ _____ |
| <input type="checkbox"/> Social Security<br>\$ _____       | <input type="checkbox"/> MFIP<br>\$ _____               | <input type="checkbox"/> Interest/Other<br>\$ _____     | <input type="checkbox"/> Medical Aid<br>type: _____          |
| <input type="checkbox"/> Self-Employment<br>\$ _____       | <input type="checkbox"/> SSI<br>\$ _____                | <input type="checkbox"/> No Income                      | <input type="checkbox"/> Veterans' Benefits<br>\$ _____      |

Number of Persons in Household \_\_\_\_\_ / Gross Annual Household Income \$ \_\_\_\_\_

- Male  Female  Transgender  
 Single, never married  Married  Separated  Divorced  Widowed  
 Parent  Guardian  No Children  Other \_\_\_\_\_

**Building Type:**  Apartment  Duplex  House  Mobile Home  Town Home  Other \_\_\_\_\_  
(other family information on reverse)

**Primary purpose of potential vehicle:**  Employment  Medical  Education  Other \_\_\_\_\_

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MN Drivers license # \_\_\_\_\_ Expiration date: \_\_\_\_\_

Do you already own a car?  No Method of Transportation: \_\_\_\_\_

Yes - Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Est. value: \_\_\_\_\_

Do you owe any money on the car?  No  Yes: How much? \_\_\_\_\_ Total Miles on car: \_\_\_\_\_

Do you have insurance:  Yes  No: Why not? \_\_\_\_\_

If you already own a vehicle, why do you need another vehicle? \_\_\_\_\_

Family information:

Household Members:	Date of Birth MM/DD/Y Y	Race	Sex M/F/T	Disability Y/N	Years of School Completed	Medical Coverage Y/N	Veteran Y/N	Valid Driver's License Y/N	Have a Working Vehicle Y/N	Registered voter Y/N
1. Head of Household: (Applicant's name)  SSN:										
2. Name:  SSN:										
3. Name:  SSN:										
4. Name:  SSN:										
5. Name:  SSN:										
6. Name:  SSN:										
7. Name:  SSN:										
8. Name:  SSN:										
9. Name:  SSN:										
10. Name:  SSN:										

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_