Please mail to:
Unit: _____
Address: _____
Worker: _____

REQUEST FOR INDIVIDUALIZED TRANSPORTATION SERVICES

Last Name _____ First Name _____ M.I. _____ Case Name _____ Case No. _____ Date of Birth _____ Sex (M/F) _____

Street Address _____ City/State _____ Zip Code _____ Telephone No. _____

I. CLIENT: THIS SECTION MUST BE THOROUGHLY COMPLETED OR IT WILL BE RETURNED TO YOU

A. Are you able to use public transportation or can someone regularly transport you to obtain medical services? _____ (Yes / No)
(If you answer yes, you will not be eligible for individualized transportation services.)

B. Explain why you should receive individualized transportation: _____

C. List the names of your medical providers, frequency and the locations for which you need individualized transportation:

D. I certify that the above information is true and accurate to the best of my knowledge.

Signature of Recipient or Legal Guardian _____ Printed Name of Recipient or Legal Guardian _____ Date _____

II. LICENSED PHYSICIAN: COMPLETE INDIVIDUALIZED TRANSPORTATION NEED ASSESSMENT

A. Diagnoses:

1) _____ 2) _____ 3) _____

B. Provide an explanation of all physical and/or mental impairments: _____

C. Provide an explanation whether your patient's impairment(s) will be temporary or permanent: _____

D. List all assertive devices (i.e., wheelchair, walker, cane, etc.): _____

III. LICENSED PHYSICIAN: COMPLETE CERTIFICATION OF INDIVIDUALIZED TRANSPORTATION REQUEST

A. I certify that it is medically necessary for _____ (Recipient's Name), to be granted access to:

taxi ☐ curb–to-curb (van/Handi-van) ☐ door-through-door (Handi-cab) ☐ services from _____ (Month/Year) to _____ (Month/Year)

Signature of Licensed Physician _____ Printed Name of Physician _____ Address _____ Phone No. _____

AFTER COMPLETING SECTIONS II AND III, PLEASE MAIL FORM TO THE ADDRESS LISTED ON THE UPPER RIGHT CORNER

IV. WORKER: AUTHORIZATION IS TO BE COMPLETED AT EACH ELIGIBILITY REVIEW FOR A PERIOD NOT TO EXCEED ONE (1) YEAR

APPROVAL _____ (is) (is not) GRANTED FOR _____ (taxi / curb-to-curb / door-through-door) FROM _____ (Month/Year) TO _____ (Month/Year)

Signature of Eligibility Worker _____ Printed Name of Eligibility Worker _____ Date _____