DATE: _____

TRANSPORTATION REQUEST

DO YOU HAVE MEDICAID OR MEDICARE? _____

ARE YOU A VETERAN/SPOUSE OF/WIDOW OF VET? YES NO VET ID # _____

CLIENT NAME: _____

CLIENT ADDRESS: _____

CLIENT PHONE #: _____ SOCIAL SECURITY #: _____

BUILDING NAME: _____ BLDG. #: _____

APT #: _____

DATE OF BIRTH: _____ CASE #: _____

CLIENT DEGREE OF DISABILITY: _____

CLIENT CATEGORY: _____ FUNDING SOURCE: _____

CONTACT NAME & ORGANIZATION: _____

CONTACT PHONE #: _____

DESTINATION: _____

DR. NAME: _____ TYPE OF DOCTOR: _____

DR. ADDRESS: _____ DOCTOR PHONE #: _____

CITY: _____ BLDG. NAME: _____

TIME OF APPT: _____ TIME OF RETURN: _____

DATE OF APPT: _____ DAYS PER WEEK: _____

SINGLE TRIP: _____ CONTINUING TRIP: _____

DATE START: _____ DATE FINISH: _____

FARE OR DONATION: _____ SUGGESTED PROVIDER: _____

COMMENTS

CLIENT CATEGORY	DEFINITION
S.A.	60 or over - - walks with minimum assistance
S.S.	60 or over - - needs assistance or device to walk
S.W.	60 or over - - wheelchair
D.A.	under 60 - - - walks with minimum assistance
D.S.	under 60 - - - needs assistance or device to walk
D.W.	under 60 - - - wheelchair