Municipal Medical Transportation Service
TRANSPORTATION ELIGIBILITY FORM

Name:(please print)_____ **Birth Date**___/___/____

Address:_____

City _____ **Zip Code** _____

Telephone # _____

Please describe your home's exterior_____

Is the house number on the house or mailbox?_____

Do you have a physical disability? Circle one. **Yes** **No**

Do you have a mental disability or cognitive impairment? Circle one. **Yes** **No**

Do you have *Medicaid as a form of insurance*? **Yes** **No**

Note: Individuals under the age of 60 must provide proof of their disability from the Social Security Administration.

Do you use a mobility aid? i.e. wheelchair, walker, cane, scooter? Please list.

_____

Can you get into a car unassisted? Circle one! **Yes** **No**

Emergency Contact information:

Name_____

Address: _____

Telephone #_____

- Please mail or deliver the completed form to:

Participating Senior
Center or Human
Service Agency

- *To minimize abuse, all trips are subject to random audit.*
- *Service is not available to Nursing Homes.*

We reserve the right to deny transportation to any individual who does not meet the criteria for the transportation program.

I have read and understand the guidelines of the municipal medical transportation service, which is attached.

_____ _____
Client Signature Date

2020-2021