Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS**

**Your reply is REQUIRED within 15 days in order to continue using this service.**

\_\_\_\_\_\_ 1. Do you or a member of the household own a vehicle?

\_\_\_\_\_\_ 2. Do you have a valid driver’s license?

\_\_\_\_\_\_ 3. Does a friend or relative have a vehicle available?

\_\_\_\_\_\_ 4. Could a volunteer with a private vehicle take you?

\_\_\_\_\_\_ 5. Could a volunteer from a public or private agency take you?

\_\_\_\_\_\_ 6. Can another transportation service provided for free by any other agency take you?

 7. How do you get to your non-medical appointments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ 8. Can you walk to your medical appointments?

\_\_\_\_\_\_\_ 9. Can you use the public bus system?

\_\_\_\_\_\_\_ 10. Have you ever applied for paratransit or other public transport?

\_\_\_\_\_\_\_ 11. Are you mentally or physically disabled?

\_\_\_\_\_\_\_ 12. How do you get to your non-medical appointments?

\_\_\_\_\_\_\_ 13. Do you have a condition that requires medical services on an ongoing basis?

\_\_\_\_\_\_\_ 14. Could you reschedule if transportation were not available?

If you answered YES to any of the above questions, please tell us why you require this service.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign and return. Thank you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature) (Date)

**In addition to this questionnaire, please have your physician complete the enclosed certification form and return it to our office as soon as possible.**

For Official Use Only

Referrals to other resources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eligibility Determination: \_\_\_\_\_ Eligible \_\_\_\_\_\_Ineligible Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised-4/22