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***? Circle one ☐ **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:

Waterford Senior Services
24 Rope Ferry Rd.
Waterford, CT 06385

- ***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

2024-2025