

**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:

THRIVE 55+
102 Newtown road
Groton, CT 06340

- *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